

Narrative Structures of Maya Mental Disorders:

An ethnography of Q'eqchi' healing

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ABSTRACT

A wealth of research into medical and healing traditions of Maya communities has been conducted. Previous research has also explored unique conceptions of health and disorder held by Maya peoples. This study adds the voices of Q'eqchi' Maya healers of southern Belize to this accruing research. Working from Indigenous research paradigms, a nine-month ethnographic study with six practicing members of the Q'eqchi' Healers Association (QHA) of Belize occurred. The QHA is an endogenous grass-roots association formed in 1999 to preserve Maya medical knowledge and healing practices. In collaboration with the QHA members, this research focused on the healers' conceptualizations and treatments of mental illness and disorders. During ethnographic research, 94 in-depth qualitative interviews with the six members of the QHA and 43 observations of healing encounters occurred. Twenty-six additional interviews were held with patients and participation in other healing ceremonies and cultural gatherings frequently took place. From the analysis of these data, there are 17 different mental illnesses and disorders recognized by the Q'eqchi' healers that fall within one of four broad "narrative genres." The main argument of the dissertation is that these "narrative genres" are epistemological structures that the healers use to "read" and "emplot" specific cases of illness to which they attend. Since narrative theory and research focuses largely on individual patient experiences, this study expands contemporary theory by looking at the Q'eqchi' healers medical epistemology through a narrative lens. It is argued that a deeper understanding of Q'eqchi' conceptions of mental illness and disorder can also aid dialogues between the "traditional" healers and biomedical practitioners working within the Belize Ministry of Health while also improving the treatment of Q'eqchi' patients. This research adds to the areas of applied ethnography, narrative theory, Indigenous epistemology, cultural psychiatry, medical anthropology, and medical pluralism.

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DEDICATION

To the Maya healers of Belize.

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CHAPTER I: Q'eqchi' Healers of Belize

The truck slowly bumped and jerked its way across the muddy road as it approached San Filipe, one of the 32 Maya villages scattered across the southern Toledo district of Belize. Lines of colourful clothing—bright greens, oranges, pinks and blues—drying easily under the heat of the morning sun, extended some twenty meters across well kept grassy lawns and provided a striking contrast with the faded wood walls and brown thatched roofs of the typical Maya homes. The Q'eqchi' expression, *chaab'il*, meaning beautiful or attractive to the eye, seemed appropriate for such a vision. Within close proximity to most household units, proud and brightly dressed women attended to the various needs of the home and family. The youngest children of the family could be seen peeking around corners and breaking the calm rural air with occasional bursts of laughter. Not yet ready for formal schooling, those children under the age of five followed their mothers around, helping with household activities in their own small ways.

When we arrived at our household destination in San Filipe, there were no colourful laundry drying in the sun and no children were playing. The grass grew long. Francisco and Carlos walked steadily from the parked vehicle into the typical Q'eqchi' style home with dirt floors, several hammocks suspended from the roof of the main open room, brightly coloured plastic lawn chairs and buckets around the edges, a central hearth radiating warmth beyond its old cement edges, and several smiling children stood about. Carlos's wife, Carmella, wearing a bright orange dress, lay sprawled out on a nylon hammock; one hand on her stomach, the other on her forehead. She said nothing as we entered. Carlos seemed concerned, yet hopeful.

Upon entering the home, Francisco pulled his "examination stool," an upside down white plastic bucket, beside Carmella's hammock and, while closing his eyes amid the distractions in the home, immediately began his work.

Francisco first hunched over slightly to assume a posture of prayer, his right hand on his own forehead and his left placed on Carmella's. After several minutes, Francisco slowly and cautiously pushed his flattened hands into Carmella's stomach as she lay motionless in the hammock. After another moment he returned his hand to her forehead. For several minutes, Francisco repeated the firm massage to the stomach area while in constant prayer. Two older girls with baby in hand looked on from across the room. Three small boys were quietly laughing and playing near some bags of corn, unconcerned with the other happenings in the home.

After several more minutes of massage and prayers, Francisco, hands hovering about five centimetres above Carmella's body, moved both his hands from the forehead down across her stomach and down to her legs, never making contact with her body—a common healing procedure referred to as *jilok* or a “spiritual massage.” After four of these sweeping movements across her body, Francisco paused at Carmella's feet. While holding the tops of her bare, dusty feet with his thumbs, he continued with his prayers. After satisfied with this process, nearly ten minutes after arriving in the home, Francisco moved his right hand in a cross-like motion over Carmella's body, signalling that his work for today had come to an end. Francisco then slid the white plastic bucket across the floor and moved to the doorway of the modest home.

Following this medical encounter, Francisco and Carlos exchanged several words while Carmella remained motionless in the hammock. Francisco talked about her condition and what further treatments were required. Carmella suffered from headaches and stomach cramps, and had experienced these symptoms for the past three days. The phrase *tib'l jolom*, often referring to a mild condition impacting the mind of a person due to high levels of stress, was repeated several times during their conversation. The prognosis was positive and Carlos was optimistic. Francisco then reached in his small sack and pulled out a handful of medicinal plants and handed Carlos a

few leaves of a common plant called *saxjolom chacmut* (feather of Curassow's head). Carlos then questioned Francisco regarding the preparation of the medicinal plants, asking, "hot or cold?" *Ke* (i.e., cold) was Francisco's reply. After a few more moments of cheerful discussion, Francisco bade farewell to Carlos and his family, stepped out into the morning sun, and walked back to the truck to continue his work.

Contemporary Healing as "Traditional" Medicine

Francisco Caal has been a Q'eqchi' Maya traditional healer or "bush doctor" in the southern Belize region for nearly 40 years. The Q'eqchi' word, *aj ilonel*, stemming from the verb *ilok*, "to see," is often used to describe the work of a traditional healer, translating roughly as "seer" or the "one who sees," involving the ability to prognosticate disease.¹ As a practising *aj ilonel*, Francisco's service to his community situates him amidst a vast and diverse area of specialized Maya medical knowledge. It could be argued that this knowledge is among the "great medical traditions" that have distinct historical continuity going back thousands of years, such as India's Ayurveda, classical Greek and Greco-Roman medicine, Chinese medicine, Unani-tibb, and the Greco-Arabic tradition (Ross, 2012).

When we speak of Maya medical knowledge or Maya medicine it is important to first acknowledge that "Maya" as an ethnic signifier was not traditionally invoked by the inhabitants of Central America (Coe, 1999; Kahn, 2006; Watanabe & Fischer, 2004; Wilson, 1993; 1995). As Little (2004) suggested, contemporary scholarship, geopolitical developments, and grass roots responses to forces of modernization and globalization have worked in consort to construct a notion of "Mayaness" that is today applied across Central America's broad geographical and temporal landscape. The term "Maya" often invokes a notion of singularity today, something

¹ The Q'eqchi' term *aj ilonel* is singular. The plural *aj iloneleb'* is also used when talking about a group of healers. The English word healer and Q'eqchi' term *aj ilonel* are used interchangeably throughout.

akin to the term “Aboriginal” in Canada or “Indigenous” more globally. There are, however, thirty-one distinct Maya cultural groups with mutually unintelligible languages inhabiting today’s nations of Mexico, Guatemala, El Salvador, Honduras and Belize. As previous research attests, the estimated seven million people comprising contemporary Maya communities share a rich healing tradition and situated medical knowledge (Ankli, Sticher, & Heinrich, 1999; Ankli, 2002; Cichewicz & Thorpe, 1996; Comerford, 1996; Eder & Pu, 2003; Fabrega & Silver, 1973; Groark, 2008; Harvey, 2006; 2011; Kunow, 2003; Schuster, 2001; Wilson, 2007), adding strength to the claim that Maya medicine, in all its variety and local adaptations, is great indeed.

In Belize today there are three recognized Maya language groups: the Yucatec, Mopan and the Q’eqchi’. These are spoken by over ten thousand of the roughly three hundred thousand total Belizean population. Francisco is a Q’eqchi’ Maya and like most other Q’eqchi’ peoples in Belize, he lives in the southernmost region of the Toledo district. When he is not attending to patients, Francisco spends time with his family, collects firewood in the surrounding forest areas, works on his herbal garden, helps family and friends with their subsistence farming activities, participates in community building projects, or relaxes in a neighbourhood pub. As a result of their relative remoteness, some authors argue that the Q’eqchi’ of southern Belize are the least “acculturated” of the Maya language groups and have maintained a highly “traditional” way of life (Pesek et al., 2009; Treyvaud-Amiguet et al., 2005), that is a cultural continuity with the attitudes, customs and perspectives of previous generations. Although these observations have merit, the current research seeks a contemporary reading of local Maya communities to avoid the essentialist or romantic ideas of Maya culture promoted by many (e.g., Arvigo, 1994; Balick, De Gezelle, & Arvigo, 2008). So-called “traditional” Maya knowledge, as it exists today, is a syncretism of pre-Columbian knowledge that was introduced by the Spanish, English and other

groups over the last several centuries. As Waldram, Cal and Maquin, (2009) and others (Thompson, 1930; Maurer, 1997; Kahn, 2006) observed, elements of English Protestantism, Spanish Catholicism, Afro-Caribbean religions, biomedical services, North American popular culture, and neo-liberal ideologies have fused with and reshaped contemporary Q'eqchi' cultural life, including local medical practices and treatment approaches. This is not to say that continuities with the past are not a reality. As observed throughout this work, there are aspects of Francisco's healing practice and epistemology that trace their way back to pre-contact days when Central America was punctuated with beautifully erected limestone cities. This perspective of "tradition" is mentioned here to remind us that the melange of cultural knowledge and contemporary Q'eqchi' cultural life cannot easily be separated into coherent compartments ready for analysis. Nor should this be the goal of a sound research project. Rather, when speaking of local Q'eqchi' communities this research adopted a critical stance towards claims of static "traditional" knowledge that are insulated from externally generated influences. In this way, the term "tradition" recognizes historical continuities, but at the same time leaves room for their variation and flux overtime, their necessary and continuous contact with and adaptation to other cultural systems and ways of life. Indeed, as previous research attests, cultural knowledge and practices are modified by social and political change and are heteroglossic, fluid and permeable across time and space (Good, 1994; Hatala, 2013; Keesing, 1990; Lock & Scheper-Hughes, 1996; Susser, 2009). These characteristics are evident when exploring the medical knowledge and healing practices amidst contemporary Q'eqchi' communities.

As an *aj ilonel* or Q'eqchi' healer, Francisco's treatment approach typically centers around sensory or performative aspects in various combinations, including herbal medications, healing prayers, spiritual ceremonies, burning of incense, and physical intervention, all blending

together in any particular treatment encounter. In most cases, treatment approaches carefully and logically follow from a rich network of causal ontologies, etiological perspectives, nosological systems, and prior empirical observations. As such, the healing practices of Q'eqchi' *aj iloneleb'*, like healing among several other Indigenous communities, can be described as esoteric and eclectic (Harvey, 2006; Ross, 2012; Waldram, 2000; 2013). While there exists an identifiable and somewhat consistent practice of Q'eqchi' healing (i.e., a detailed understanding of the body, mind and spirit including their sicknesses and treatments), there are no formal schools for training and no coherent codified texts for study. Fifty years ago, Francisco apprenticed under a healing master who passed on the knowledge he learned from his own master. Francisco's apprenticeship combined with the accrued empirical knowledge from many years of individual practice constitutes his detailed body of complex and locally situated medical knowledge. This knowledge can, of course, vary from one *aj ilonel* to the next, as each is usually apprenticed under a different master. Based on experience and the type of cases they observe during service, each healer adds a particular flavour to his or her craft. Again the notion of a contemporary Q'eqchi' healing "tradition" must be understood in this fluid and plural context: multiple "authoritative" Indigenous perspectives on a particular illness as well as "non-Indigenous" ideas are constantly being negotiated with so-called "traditional" Indigenous philosophy and healing practices (Lewton & Bydone, 2000). There are times when Francisco openly rejects ideas from other *aj iloneleb'* or epistemic philosophies such as biomedicine or Spanish Catholicism based on his own authority and medical knowledge. At other times, Francisco openly and seamlessly integrates these ideas into his own medical practices. Francisco and several other *aj iloneleb'* in the Toledo district, for instance, invoke "the Father, the Son, and the Holy Spirit" at the beginning of their healing prayers and make a sign of the cross over their

patients to signify the completion of a therapeutic encounter. In most cases, these are not seen as external features of Q'eqchi' medicine imposed through colonialism and conquest, but rather part of their "traditional" practice. Indeed, Waldram, Cal, and Maquin, (2009) observed that,

None of the older, Christian-related or the more recent biomedical practices are seen as a threat to Q'eqchi' healing tradition or heritage per se. Rather they are elements of an evolving model of 'best practices' that ensures contemporary, leading edge, and competent care for their patients (p. 46).

Thus, Francisco and his *aj ilonel* colleagues are not so much concerned about issues of identity or authenticity regarding their medical practice, but rather empirical issues of reliability, validity and efficacy. This perspective leads *aj iloneleb*' to adopt a pragmatic "whatever works" approach to their healing vocation (Waldram, Cal, & Maquin, 2009; Waldram, 2013).²

The foregoing should prepare the reader for a certain ambiguity through the following ethnographic analysis. There are times throughout this work when several *aj iloneleb*' agree with Francisco regarding a diagnosis and treatment approach. There are also many times where several *aj iloneleb*' disagree. This ambiguity is not detailed to undermine the authority, effectiveness or sophistication of the Q'eqchi' healers and their knowledge. After all, this diagnostic differentiation is also observed among North American physicians operating within biomedical frameworks (Browner & Preloran, 2010; Loring & Powell, 1988). As such, no substantial difference is suspected between this aspect of the Q'eqchi' healers' day-to-day work and biomedical practitioners. As Good (1994) suggested, this diagnostic and therapeutic variability is an important, but often subtle, part of medical practice, which necessarily involves the complex cultural work of semiotics and interpretation. Thus, the aim here is to highlight the points of divergence as well as convergence and the juxtapositions between points of agreement

² See also discussion of "tradition" on page 15.

and contestation. Although requiring a certain degree of comfort with ambiguity, such an approach should garner in the reader an appreciation of the pragmatic everydayness of “traditional” Q’eqchi’ medical practice.

Globalization and the Local Landscape

Throughout his fifty-years as a Q’eqchi’ healer, Francisco has witnessed growing trends within many Maya communities away from the utilization of local healing services in favour of available biomedical services (Hawkins & Adams, 2007; Kahn, 2006; Landy, 1977; Watanabe, 1992). When one observes a desperate Q’eqchi’ Maya family waiting in line for medication at the local hospital, or from the random and chaotic visits from American “medical missionaries,” or from the Psychiatric Nurse Practitioners (PNP) operating more and more in the rural areas, one cannot help but envision the subjective experiences of these Maya families being completely “embraced,” either through their own volition or against it, by the political and cultural economy of hope that underlies the biomedical ethos (Good, 2007). When Mary-Jo DelVecchio Good (2007) spoke of the “medical imaginary,” that which energizes medicine and makes it an intriguing enterprise, it seems obvious that such an imaginary would impact the local medical practices and knowledge of a people not yet subsumed by the salvific narrative it embodies. As the professional and popular culture of biomedicine has significantly extended its authority and power in Belize in recent years, it is not surprising that a growing number of Maya peoples are being “embraced” by and embracing it (Good, 2007).

The steadily declining authority of Q’eqchi’ “traditional” healing services is only in part related to the spread of biomedicine. Even in some areas where there are no meaningful biomedical facilities, growing opposition to the philosophy and epistemology of Q’eqchi’ healing is apparent (Finkler, 1985). From about the 1950s onward, Christian evangelical

churches from the United States, often in consort with biomedical personnel, or “medical missionaries,” have been working, either explicitly or implicitly, to discredit and undermine the authority of the local healing system of the Maya and other Indigenous healing practitioners (Molesky-Poz, 2006; Staiano, 1981). Thus, no longer are local *aj iloneleb*’ the reputable “bush doctors” of the past. Today it is not uncommon for them to be labelled as harmful “witch-doctors” or “evil-doers,” by some of their own people as well as others (Watanabe, 1992; Waldram, Cal, & Maquin, 2009).

Not surprisingly then, several Q’eqchi’ healers in southern Belize are disheartened because of the lack of interest young people are showing regarding local healing practices and their philosophical underpinnings. As Kahn (2006) and Bolland (2003) observed, with forces of globalization providing access to new forms of technology, media and neo-liberal ideologies, the younger generations, even in what could be considered the most remote villages, are becoming less and less interested in the often arduous work of a local Q’eqchi’ healer. Acquisition of subsistence knowledge, including that of localized medical practices, is simply less of a priority for younger generations as urbanized life becomes normalized (Zarger, 2002).

Finally, cutting across these distinct yet related socio-political movements are the bleak economic realities of an increasingly improvised Central American region (Coe, 1999; Government of Belize, 2004). As several authors argued, historically entrenched transportation and structural problems associated with the legacy of British colonialism have left major segments of the Belizean population in poverty for a considerable period (Killion & Cayetano, 2009; Kirmayer & Minas, 2000). Higher concentrations of poverty now exist in the southern rural areas among the Mopan and Q’eqchi’ Maya (Government of Belize, 2007), where these Maya communities are almost twice as likely to be impoverished as compared to those in urban

areas (44% compared to 24%). As pressure rises for financial stability and economic development, including semi-sustainable farming activities, there are significant encroachments on lands historically used for harvesting medicinal herbs and medicines (Bourbonnais-Spear et al, 2005; Pesek et al., 2010; Pesek et al., 2009). As a result, Francisco and his colleagues are forced to travel even further distances to access healing materials vital to their work. *Aj iloneleb'* today fear that many traditional medicines might no longer be found in the future.

Global descriptions of post-colonial subjectivities, narratives of disrupted experiences, and historical processes of disintegration have been extensively and critically documented by medical anthropologists, health activists, and Indigenous scholars (Battiste, 2000; Das, 2007; Dei, Hall, & Rosenberg, 2000; Farmer, 2003; Good & Good, 2010; Good et al., 2008; Henderson, 2000; James, 2004; Kleinman, Das, & Lock, 1997; Kovack, 2010; Smith, 1999; Susser, 2009). The current research does not intend to reproduce the narratives of globalization and change witnessed by Francisco and countless others over the years. Nor is the intent to dwell on images of suffering, passivity, ignorance, and stigma which can become prevalent in discourses of healing and illness, especially those concerning individuals and communities suffering from mental illness in impoverished nations (Desjarlias et al., 1995). Rather, following Ida Susser's (2009) important reflections, the goal is to document in the following ethnographic analysis the many ways in which contemporary Q'eqchi' Maya medical practices and knowledge systems—especially those related to the promotion of mental health—persist despite a steadily changing landscape. Thus, in presenting the current research, there is a conscious focus on describing “avenues of hope” as this research honours and “envision[s] the possibility that, powerful as it is, globalization has not displaced the ingenuity and agency of people and groups at the local level” (Susser, 2009, p. 4). The presentation of this research, therefore, begins by

describing the formation of a rather unique association of local Q'eqchi' healers. Against this backdrop of socio-political change, globalization, and local disintegration, these *aj iloneleb'* are making important choices to unite and strengthen what they know to be good, to foster hope.³

The Q'eqchi' Healers Association

The idea and motivation to form the Q'eqchi' Healers Association (QHA) in the Toledo district of Belize was born in 1999 in response to growing concerns over the erosion of Q'eqchi' cultural practices, especially those related to local medical knowledge and care. Several *aj iloneleb'* in southern Belize, community development specialists, and members of the Q'eqchi' Council of Belize, came together to form the association. During this time, a member of the Q'eqchi' Council who was also a practising healer visited some of the other healers in the district and initiated conversations about the idea of an association that would promote their work while assisting in the protection of important natural resources, especially medicinal plants (Pesek et al., 2009; Treyvaud-Amiguet et al., 2005). Because the practice of Q'eqchi' medicine is typically a solitary activity in which one *aj ilonel* operates largely in isolation from the others, the idea of forming an association of healers for collaborative purposes represented an intriguing ontological shift in its practice (Waldram, Cal, & Maquin, 2009). Since the QHA embodies a new and responsive, quasi-professional way of organizing traditional medical services, it is not surprising that some Q'eqchi' healers in southern Belize were initially unsympathetic to its goals. During discussions with elders, community members and knowledge experts, it became clear that some

³ The concept of “hope” employed in this research takes on multiple meanings. The first usage of the concept is in relation to Good’s (2007) work wherein she discussed the hope engendered by the biomedical imaginary and described how this type of hope can impact the reliance once placed on “traditional” medical systems. This relatively new hope within Q'eqchi' communities of southern Belize can, in many ways, become an obstacle to the “ethnic revivalist” goals of the QHA (Wilson, 1993; 1995). The second usage of “hope” references Susser’s (2009) “avenues of hope” wherein she documents the persistence of local knowledge and Indigenous agency in the face of globalization and modernization. This is the hope that is fostered by the current research enterprise wherein it is suggested that by documenting their healing epistemology and treatment approaches more collaboration and dialogue can occur between the “traditional” Q'eqchi' healers and the Ministry of Health in Belize.

of the *aj iloneleb*’ were unsure of the benefits; others were concerned that their knowledge would be abused, taken or sold. Still others were afraid that their collective efforts would attract unwanted attention, including sorcery or witchcraft from individuals hostile to the group. In the middle of the rainy season in 2000, after lengthy deliberations, thirteen healers in the Toledo district committed to the idea of the QHA. Willing to work together, these individuals ultimately laid the groundwork for a grass-roots endogenous effort to strengthen, promote and preserve Q’eqchi’ medical knowledge and practice (Arnason et al., 2004; Pesek et al., 2007; Waldram, Cal, & Maquin, 2009).

Official membership in the QHA is regulated entirely by the healers themselves. Since 2000, membership has fluctuated because of employment opportunities in the urban centers of Belmopan and Belize City, personal issues, and the expulsion of association members due to breaches of agreed-upon ethical guidelines. There were nine Q’eqchi’ healers from the Toledo district actively engaged in the work of the association in 2003. The founding member of the association, Albino Maquin, passed away in late 2006 in his mid-90s; two other healers moved to the Northern districts in search of work and financial stability in 2009. The current research thus details the experiences of Francisco and five other Q’eqchi’ healers, all of whom are men, and who remained active in the association throughout 2011: Emilio Kal, Manuel Choc, Lorenzo Choc, Augustino Sho, and Manuel Baki.⁴

Emilio Kal, Francisco’s younger brother, is regularly involved in the QHA, and has up to 12 patients at any given time, primarily in the Western villages deep within the shade of the

⁴ There were no women healers who took part in the QHA at the time of this research. There are female Q’eqchi’ healers who have been working with researchers from the New York Botanical gardens and discussions have occurred regarding the integration of these women with the male healers with the same goals and intentions that spurred the formation of the QHA. However, several community members felt this was too premature as women and men are still separated by traditional cultural hierarchies that persist today. There are studies that include women’s health in particular (Ekelman, Bazyk, & Bello-Haas, 2003), but research looking into the knowledge of women Maya healers is limited.

Maya mountains spanning the Belize-Guatemalan border. In his early 40s, Emilio has been practising as an *aj ilonel* for roughly 20 years. His motivation to learn the practice was primarily to provide health assistance for his family and other community members in remote and impoverished areas with limited access to government-sponsored health services. Emilio is also a practising *k'atol mayej* or *k'atol xam*, a “spiritual guide” (i.e., the one who burns the ceremony or fire in a literal translation from the Q'eqchi'). Molesky-Poz (2006) referred to these individuals in the *K'iche'* Maya language as *Ajq'ij*, the sacred spiritualists who are to be “of the days” or “in charge of the days.” They have the specific role of offering petitions and thanksgiving in rituals and illuminating life experiences according to the Maya sacred calendar, cosmovision and worldview. Since Emilio is the only QHA member trained in this special knowledge from Chimaltenango, Guatemala, he has an important role in facilitating spiritual ceremonies at the beginning of QHA meetings and other community gatherings. Serving as a “spiritual guide” adds a unique aspect to Emilio’s healing practice which incorporates elaborate spiritual symbolism and ritual inspired from traditional Maya cosmovision (Molesky-Poz, 2006). At the time of this research, Francisco was apprenticing under his brother and much of the ceremonial work observed for healing purposes was actually conducted in tandem.

Manuel Choc and Lorenzo Choc are both in their early 70s and are less regularly engaged in healing work than the other members of the QHA, seeing patients about once a month. Their client load is more a reflection of their age and physical condition than their knowledge or reputations as healers. Manuel and Lorenzo trained to serve their communities as *aj iloneleb'* in their early 20s, making over a hundred years of cumulative knowledge and experience between the two. Both are well respected elders in their communities and are actively engaged in the work of the QHA.

Manuel Baki is in his mid-80s and is currently the eldest *aj ilonel* active in the association. Although essentially retired as a practising Q'eqchi' healer, Manuel Baki still receives house calls from patients from time to time. He was inspired to learn Q'eqchi' medicinal knowledge at the age of 30 because his wife contracted a serious illness. His wife is alive and well today, and Manuel has continued to serve his community for over 50 years. Augustino Sho, a Mopan Maya, is a full-time teacher in one of the westerly Toledo villages and is only involved in the QHA when not teaching. He has been practising for over 15 years primarily on members of his family and close friends; he is not actively seeking patients from the wider community because of his commitment to education.⁵

Since its formation, the members of the QHA have engaged in several initiatives designed to promote Q'eqchi' heritage, culture and values among their own peoples. These initiatives could be considered as part of a broader “ethnic revivalism” amongst several Maya communities in Central America (Wilson, 1993; Kahn, 2006). With assistance from Canadian botanist, John Arnason, and his colleagues from the United States and Costa Rica, the QHA created a medicinal plant garden called “*Itzamna*” (i.e., the Maya god of the sky, the God of medicine and the father of science and the arts). For the last several years, *Itzamna* has been a “home” for the Q'eqchi' healers from which medical herbs and plants are harvested in a sustainable manner. *Itzamna* also provides the space for research activities and educational tours (Arnason et al., 2004; Rojas et al., 2010; Pesek et al., 2010). To assist in the promotion of their aims, occasional awareness campaigns and educational materials about the QHA are prepared and presented on local radio programs and at cultural events such as the Maya Day celebrations.

⁵ During meetings in the summer of 2013, the members of the Q'eqchi' Healers Association decided collectively to change the name of the association to the Maya Healers Association. This decision signals their openness to a wider degree of membership and better reflects the membership of Augustino Sho as a practicing Mopan healer. The Q'eqchi' Healers Association was the name at the time of this research and so is still used throughout.

Another important aspect of the QHA is the development of a professional ethos to support and, in a sense, help to legitimize its work. With the assistance of medical anthropologist James Waldram, the QHA has created certificates of competency and identification cards declaring each *aj iloneleb'* to be a “certified member of the Q’eqchi’ Healers Association of Belize” and a “fully qualified traditional healer and herbalist” (Waldram, Cal, & Maquin, 2009). The QHA has also developed a list of ethical rules of conduct stating the “right” ways to behave as an *aj ilonel* and explicitly condemning any form of malpractice such as witchcraft with the intent to harm others. All of the healers in the QHA agree that these ethical guidelines are crucial to strengthen their own work amongst Q’eqchi’ communities and to gain the respect of larger, more sophisticated institutions such as the Ministry of Health in Belize.

Amidst a backdrop of globalization, modernization, and rapid societal change, these *aj iloneleb'* are asserting their legitimacy as medical practitioners and knowledge experts. They do so not only by appeals to “traditional” ways and knowledge as a means of legitimizing their work, but also through research and collaboration with bioscientists, biomedical practitioners, and medical anthropologists. Thus, these healers are drawing on both ancient traditions and modern technologies to substantiate themselves as “active agents” in the ongoing cultural reconstruction of their identities as Q’eqchi’ traditional healers (Wilson, 1993, p. 136). In this contemporary fusion of traditional knowledge and scientific research, *aj iloneleb'* in the QHA work together to rightly gain the attention of their own Q’eqchi’ communities, the Belize biomedical community, and the world scientific and research community.

A Q’eqchi’ Program of Research: Prioritizing mental health

Over the years, broader scientific research on Maya healing traditions has focused on many different areas (Blanchard & Bean, 2001; Eder & Pu, 2003). Several studies have explored

the nature of physical manipulation or manual medicine, such as abdominal massage and bone setting (Berry, 2006; Hinojosa, 2002; Paul, 1976; Wilson, 2007). Others have focused on the use of medicinal plants and herbs, with most of the recent research by biologists and botanists (Amiguet et al., 2006; Bourbonnais-Spear et al., 2005; Camporese, 2003; Leonti et al., 2003; Medina, 2003; Nigh, 2002; Treyvaud-Amiguet et al., 2005). Another series of studies has explored the spiritual, sociological, and ceremonial aspects of Maya healing, including cosmology and epistemology (Fabrega & Silver, 1973; Harvey, 2006; Kunow, 2003; Molesky-Poz, 2006; Watanabe, 1992). Surprisingly, the voices, knowledge and stories of local Q'eqchi' healers practising in southern Belize are largely absent from the accruing research into the diversity of Maya medical systems. This is an unfortunate gap which the QHA and present study intended to address.

During conversations with *aj iloneleb'* in southern Belize regarding the formation of the QHA, there had been a keen interest to initiate a Q'eqchi' research program. This research would add to the burgeoning field of Maya medical research generally and aid in demonstrating to their own people and others the legitimacy and effectiveness of their healing work specifically. The healers in the QHA are not concerned that the outcome of any scientific research could damage their credibility. Instead, each member strongly believes that scientific studies into their healing practices are important. As such, they have requested, monitored, and sustained all research efforts regarding the various aspects of their medicinal knowledge and practice (Arnason et al., 2004; Waldram, Cal, & Maquin, 2009).

Under the invitation, direction and guidance of Victor Cal (coordinator of the QHA and director of the Belize Indigenous Training Institute (BITI), community development specialist, traditional knowledge educator, and close friend of the healers), research was initiated.

Collaborative research with the QHA began with the study of specific plant medicines by botanist John Arnason from the University of Ottawa in Canada. In addition, ethnobotanical surveys and land conservation efforts were undertaken by American physician Todd Pesek from Cleveland State University. Pharmacological research from Arnason and his team already demonstrates that many plants used by the Q'eqchi' healers to treat mental illnesses such as depression and anxiety are pharmacologically active and chemically effective (Bourbonnais-Spear et al., 2005; Treyvaud-Amiguet et al., 2005).

The members of the QHA assert that, while studying their plant medicines is extremely important, it is essential that plant use be seen within the broader context of actual diagnosis and treatment. For instance, Q'eqchi' healers contend that the plants, prayers and ceremonies work in consort. In addition, they do not attempt to shield the religious or spiritual aspects of their treatments from scientific scrutiny. As such, Q'eqchi' *aj iloneleb'* argue for a “holistic” research enterprise and reject the “biological gaze” that Nigh (2002) observed has led to a distorted view of Maya medicine in the scholarly literature, a view which seeks only scientific and biological parallels while marginalizing Indigenous knowledge and worldviews. In alignment with the QHA, our research team denounces the “biological packaging of Maya medicine” and “herbal fetishism” observed elsewhere amongst research with Maya communities from Chiapas. In those cases, local medicinal practices are reduced to plants and pharmacology and stripped of “their contingency and cultural social specificity” (Nigh, 2002, p. 460). This emphasis on biological parallels that often pervades research inspired from Western epistemological frameworks is a “radically materialist thinking” that extends as “far back as Aristotle’s starkly biological view of the human soul in *De Anima*” (Lock & Scheper-Hughes; 1996, p. 46), and must be challenged for the limitations it embodies. The biological and pharmacological aspects of Q'eqchi' healing

are only part of a much larger story. For the Q'eqchi' healers, the rational existence and role of God and mountain spirits, the power of prayer and ceremony, the efficacy of sacrificial offerings, the guiding clarity of dreams, and the manipulation of pharmacologically-active plants coalesce in the treatment of their patients. Largely absent from the historical and contemporary literature are studies that bridge these separate foci to provide a comprehensive view of Q'eqchi' Maya healing that is grounded in, and inspired from, Indigenous epistemologies and worldviews.

At the urging of the QHA members, collaborative research with the association has expanded to include documentation of actual plant use in specific cases, along with the ceremonies and prayers that are integral to the Q'eqchi' medical system. In 2003, medical anthropologist James Waldram was invited by Victor Cal and the QHA healers to investigate the synergistic connection between the various domains of Q'eqchi' healing. Since then, a strong research relationship has emerged. In consideration of the needs of the rural communities in the Toledo district and under the guidance and direction of James Waldram, Victor Cal, and the *aj iloneleb'*, it was determined that the current research would focus on one aspect of Q'eqchi' medical knowledge and practice: the conception and treatment of mental illnesses and disorders.

The Mental Health Scenario in Belize

According to Francisco and the QHA members, the mental health scenario in Belize, including health intervention at the community level as well as official Ministry of Health policy and regulation, is troubling. In 2005 the Mental Health department of the Belizean Ministry of Health estimated that at least 25,000 adults of the total population of Belize (333,200) are affected by mental disorders, including psychotic disorders, depression, anxiety disorders, and substance abuse (Cayetano, 2008; World Health Organization, 2006). In that same year, 12,318 patients were seen at various psychiatric units throughout the country and in 2006 the number

increased to 14,556 (GOB, 2010). Of the total number of patients seen in 2006, 26.8 % were new patients; 73.2% were returning patients. Slightly more than one-fourth of all patients were seen for schizophrenia/psychotic disorder (26%), followed by mood disorders (19.5%), affecting roughly 1,904 men and 1,257 women (WHO-AIMS, 2008). Overall, only 49% of the total individuals estimated to suffer from some type of mental disorder are receiving any form of treatment from the government subsidized biomedical health system, reflecting a substantial treatment gap in the overall Belizean population (GOB, 2006; 2010; PAHO, 2007; WHO-AIMS, 2008).

In their commentary on the mental health system in Belize, Killion and Cayetano (2009) noted that the Toledo district, with the highest concentration of Maya communities and highest poverty rates in the country, consistently has fewer reported cases of individuals with mood disorders. These authors further speculated that lower rates may reflect a masking of clinical signs, different phenomenology of mood conditions, the existence of so-called “cultural factors” that may mitigate against disorders, or it may be that mood disorders may simply be defined as other kinds of conditions amongst Maya communities (p. 161). The low rate of mood disorders is likely due to a confluence of these various factors. Killion and Cayetano (2009) did acknowledge that the “use of Indigenous healers may be more prevalent in this region” (p. 161), yet no significant follow-up or inquiry is suggested to ascertain whether or not this is the case. Neither is the extent to which the so-called “Indigenous healers” effectively maintain and promote mental health in various rural communities taken into consideration.

The Ministry of Health has, over the years, given attention to the delivery of mental health care in Belize, which has proven fruitful in some regards. In advocating for a comprehensive mental health program in Belize, Claudia Cayetano, chief psychiatrist and

technical advisor to the Ministry of Health, has helped to establish a strong community mental health care program. In 1991, the first training program for Psychiatric Nurse Practitioners (PNPs) was established under the auspices of the Pan American Health Organization (PAHO) and the World Health Organization (WHO) in collaboration with Memorial University in Newfoundland, Canada and with support from the Canadian International Development Agency (PAHO, 2007). Today, there are eight mental health clinics spread across the country, one in every district that is maintained by PNPs under Cayetano's supervision and guidance. In reviewing the mental health system, Killion and Cayetano (2009) observed that the role of the PNP has now evolved to allow for a sizeable amount of clinical autonomy. This included independent assessment of patients, prescription of psychotropic medications and consultation with local health and social agencies. According to some estimates, the PNPs currently administer upwards of 90% of the government sponsored mental health care in the country (Cayetano, 2008; GOB, 2010; WHO-AIMS, 2008).

Again looking to the Toledo district, PNPs today maintain caseloads in clinics and travel to rural villages to provide care, extending the availability of professional psychiatric services to rural areas as best they can. Because the PNPs' work is based on a biomedical model, their treatment visits and consultations with patients primarily involve the distribution of medication (Bonander et al., 2000). One may ask whether the economy of hope within the biomedical ethos influences the perceived benefit of medications provided by the PNPs and impacts the perception and utilization of the local Q'eqchi' medical system (Good, 2007). In addition, Bonander et al. (2000) pointed out that the degree to which Q'eqchi' families follow the PNPs' treatment regimens is strongly related to the degree to which they align with or "buy in" to the PNPs' biomedical explanatory model of illness causation (p. 66). As we will see from the explanatory

models outlined by the members of the QHA in later chapters, the degree to which Q'eqchi' community members engage the biomedical explanatory system is minimal at best. Furthermore, although additional counselling and psychotherapy are provided by the PNPs on a case-by-case basis, there are currently no significant efforts to provide language translation for non-English speakers, not to mention cultural sensitivity regarding local explanatory models. As the PNPs expand their practice in Belize without acknowledging, working with or supporting the knowledge and practices of the various *aj iloneleb'*, it is likely that the hope fostered by the cultural power of the medical imaginary impacts the subjective experience of Q'eqchi' healer and patient in ways counter-productive to overall Ministry of Health goals, which includes the ethical treatment of all mentally ill patients in Belize (Cayetano, 2008; Good, 2007; Killion & Cayetano, 2009).

In terms of the official mental health policy in Belize, there are, from the local perspective of the QHA members, several reasons for a pessimistic view of this mental health scenario. The mental health legislation in Belize was, until recently, based on the British model dating back to 1965; a model of psychiatric care closely associated with “asylum psychiatry” as an early colonialist enterprise (Kirmayer & Minas, 2000). The latest addition to the legislation was enacted in 1998 after the Mental Health Association lobbied vigorously for decriminalizing suicide and ensuring that survivors of suicide attempts receive professional help rather than face criminal charges (Bonander et al., 2000). Since 2005, under the leadership of Cayetano, a national committee (comprised of psychiatric nurses, members of the Mental Health Association, key stakeholders, with technical support from PAHO and WHO country and regional offices) worked at revising and updating the mental health policy. These efforts have transformed the

mental health program in Belize from one based on institutional care to one based on community care and a focus on reducing stigma (Cayetano, 2008; GOB, 2007).

These meritorious efforts, however, poorly attend to the realities of the local Maya communities or “traditional” healing systems in southern Belize. Although it has been acknowledged that most rural Belizeans first seek medical assistance from one of the several different types of local herbalists or traditional healers before going to a government sponsored medical practitioner (Bonander et al., 2000; Killion & Cayetano, 2009; Staiano, 1981), the WHO observed that in Belize “there is no interaction between mental health facilities or personnel and alternative/traditional practitioners” (WHO-AIMS, 2008, p. 25). The current research substantiates this observation and argues that the lack of communication between medical systems is a significant drawback to say the least. Furthermore, the WHO also explicitly suggested that “some of the resources spent on the mental hospital would be best diverted to prevention training of primary health care personnel and alternative/traditional practitioners who are the gate keepers of many rural communities” (p. 25). Yet, surprisingly, the current addition to the National Mental Health Policy in Belize 2010-2015 remains entirely silent on the issue of local or traditional healers (GOB, 2010).

These critical reflections on the policy and practice of the Belizean Ministry of Health regarding the mental health scenario are not mentioned to suggest that biomedicine and modern psychiatry do not have an important role to play in the maintenance of mental health in Belize. This is surely not my perspective, for, as Lock and Scheper-Huges (1996) reminded us, one of the biggest challenges for psychological and medical research “is to come to terms with biomedicine, to acknowledge its efficacy when appropriate while retaining a constructively critical stance” (p. 44). A similar view is held by the Q’eqchi’ healers. The QHA members are

clearly aware of the emerging authority of biomedicine and its effectiveness in treating particular mental health conditions, a recognition that extends to even the most remote villages in the Toledo district. As mentioned earlier, the contemporary healing tradition of the Q'eqchi' healers is fluid, plural and, in some sense, open. It is not uncommon, for example, to see one of the *aj iloneleb'* borrowing ideas or technologies from biomedicine, including the use of over-the-counter medicine such as menthol rub and ibuprofen, snake bite kits, or the use of plastic gloves for some cases of known infectious diseases (Harvey, 2011; Waldram, Cal, & Maquin, 2009). Nor are Q'eqchi' patients entirely averse to the notion of biomedical service. Rather, the point to stress here is that Francisco and the members of the QHA wholeheartedly argue that biomedicine should be complementary with and not competitive to their own services. When considering the mental health of their patients first and foremost, a collaborative health care model is promoted by the local *aj iloneleb'*. Thus, the mental health scenario in Belize will invariably improve should collaboration and coordination between PNPs and local *aj iloneleb'* be considered more seriously.

The DSM, Culture and “Mental” Illness

To assess the mental health scenario in Belize and evaluate current treatment needs, the Mental Health department of the Belize Ministry of Health primarily draws on the diagnostic coding systems developed and promoted by the American Psychiatric Association (APA), the Diagnostic and Statistical Manual for Mental Disorders (DSM). Since the first training program for Psychiatric Nurse Practitioners (PNPs) in 1991, the DSM and related diagnostic interview tools (i.e., Diagnostic Interview Schedule (DIS) and the Structured Clinical Interview for DSM-IV (SCID)) have been the primary means by which mental illness and disorder are

conceptualized and diagnosed by the Ministry of Health (Bonander et al., 2000; Killion & Cayetano, 2009; WHO-AIMS, 2008).

The DSM was first published by the American Psychiatric Association in 1952 and emerged from systems for collecting census and psychiatric hospital statistics, research among majority populations in the United States, particularly those found in hospitals or specialty psychiatric clinics, and from an earlier manual developed by the United States Army. The first edition of the manual was 130 pages long and listed 106 mental disorders. There have been five major revisions since the DSM was first published in 1952, gradually evolving to include more disorders. There are currently over 700 different mental disorders presented in the DSM-V.

The definition and classification of mental illness and disorder is a core issue for researchers, mental health practitioners, governmental agencies and those who may be diagnosed (Good, 1997; Berrios, 1999). In the current DSM-V, “mental disorder” is the term used to describe any kind of illness or distress that impacts the mind of an individual and is defined as

A syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress and disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (p. 20).

Although researchers and clinicians have challenged the definition of mental disorder espoused by the various editions of the DSM to some extent (Alarcon et al., 2009; Wakefield, 1992; Widiger & Sankis, 2000), it is apparent that the APA's repeated attempts to define reliable categories of psychiatric disorders has significantly guided the conceptualization and treatment of mental illness and disorder around the world (Desjarlias et al., 1995; Kirmayer, 2006).

Today, the DSM provides a common language and standard criteria for the classification and conceptualization of mental illnesses and disorders. It is used extensively by clinicians, psychiatric drug regulation agencies, pharmaceutical companies, health insurance companies, researchers and policy makers primarily in North America and Europe.⁶ In recent years, however, the popularity of the DSM has rapidly grown around the world due to the medicalization of "madness" beginning in the 1980s and the ongoing globalization of biomedicine (Lock & Nguyen, 2010). The adoption of the DSM categories in several countries has occurred for as much of a political and economic agenda as it has been a genuine concern for global mental health and the under-treatment of mental illness in impoverished nations (Desjarlias et al., 1995). For example, Lakoff (2006) stated that, in order to convince the then sceptical Argentine psychiatric community to adopt the DSM categorical system, significant negotiations had to be undertaken by American pharmaceutical company representatives and psychiatrists. In this regard, Lock and Nguyen (2010) observed that "Without the diagnostic equivalence afforded by these standardized categories [what Lakoff calls "liquidity," drawing on a metaphor from economics] not only would it be difficult to market drugs specifically indicated to treat disorders as defined by the DSM, but it would also be difficult to participate in global

⁶ The International Statistical Classification of Diseases and Related Health Problems (ICD-11), produced by the World Health Organization (WHO), is another commonly used manual which includes diagnostic criteria for mental illness and disorders. The coding system used in the DSM-V is designed to correspond with the codes used in the ICD, although not all codes may match at all times because the two publications are not revised synchronously.

psychiatric research” (p. 173). The adoption of DSM categories by the Ministry of Health in Belize follows a similar story and connection with American Psychiatry (Cayetano, 2008; Killion & Cayetano, 2009; Kirmayer & Minas, 2000).

A fundamental assumption underlying the conception of mental illness outlined in the DSM—or psychological pathology in the strong biological sense—is that illness is to be located as a pattern existing in the objectified natural world as “disease” independent of our knowledge of it (Littlewood, 2002). From this empiricist perspective, psychological pathology is real and not a social construction by any means. It is experientially manifest through illness and is directly observable through imaging technologies and diagnostic procedures of natural science. As Littlewood (2002) pointed out, this objective status of disease is predicated on the ontological position of “naïve realism” wherein the world is “out there” and can be objectively discovered as such. The biological assumptions which psychiatry recalls through the idiom of “pathology” have a powerful, natural and, hence, objective status.

The emerging rationalist picture of mental illness and disorder as portrayed by Western psychiatric nosology, therefore, involves relatively discrete categories (i.e., depression, anxiety, schizophrenia), each having distinct physiological and behavioural characteristics that are amenable to specific medications or treatments. Increasingly, the basis of mental illness is thought to stem from some form of brain dysfunction which biological research on brain circuitry or genetics will eventually uncover; this is the ongoing “biologization” of psychiatry (Kirmayer & Minas, 2000). Informed largely from the biological neurosciences, this view has influenced popular understandings of mental illness and public policy around the world, steadily reinforcing the characterization of mental illness as medically treatable “chemical imbalances” (Good, 1997; Lock & Nguyen, 2010). Emerging evidence that antidepressant and antipsychotic

pharmaceuticals can relieve symptoms of mental distress, for example, are often drawn upon in contemporary discourse to argue for an underlying biological basis to mental illness and disorder (Lakoff, 2006).

Throughout its evolution, American psychiatry has remained connected to clinical medicine and is organized as a medical discipline on biomedical grounds. Most medical schools and psychiatry departments were founded during the colonial period, exemplified by Belize during its British occupation, and still maintain a “colonial culture” of hierarchy and hegemony that continues to powerfully influence and shape the contemporary clinical encounter (Kirmayer & Minas, 2000; Lock & Nguyen, 2010). Operating within a scientific “Cartesian-Newtonian worldview” (Medina, 2006), psychiatry—and especially the DSM culture of American psychiatry—has adopted an explicit scientific and materialistic outlook that emphasises the importance of reason, logic, the natural, rational and objective aspects of reality. It ignores or even denigrates the importance of religion, faith, intuition, the supernatural, the spiritual, and the sacred (Duran & Duran, 2002; Lock & Scheper-Huges, 1996; Medina, 2006; Wilson, 2008).

In 1977 medical anthropologist and practising psychiatrist Arthur Kleinman heralded a “new cross-cultural psychiatry” integrating anthropological methods and conceptualizations with traditional Western psychiatric perspectives. In many ways, Kleinman’s work reformulated and focused a critical engagement with and a counter narrative to the universalist assumptions espoused by the DSM and traditional “Western” psychiatric nosology. Kleinman was concerned with developing a rich description of the moral and socio-cultural context of individuals experiencing a variety of mental illnesses and disorders (Kleinman, 1977; 1988). Kleinman eloquently argued that culture matters, and matters significantly, for the study and treatment of mental disorders. Questioning the universality of psychiatric constructs like depression or

schizophrenia, Kleinman (1977) encouraged researchers and clinical practitioners to respect Indigenous illness categories and observed that different ways of understanding body and self, for example, could give rise to fundamental differences in psychopathology. From here, Kleinman (1988) criticised as a “category fallacy” the assumption that Western psychiatric diagnostic categories outlined in the DSM maintain their meaning when carried over or imported to a new cultural context, a categorical imposition often critiqued by Indigenous scholars as part of the ongoing colonialist enterprise (Kirmayer & Minas, 2000; Smith, 1999). That the mental illness categories in the DSM are largely assumed to provide the universal template to which other cultures and societies are compared is a historical situation more related to power, imperialism, and cultural hegemony than to issues of scientific objectivity (Foucault, 1973). Indigenous psychologists and researchers argue that blindly importing Western “colonial” conceptualizations of illness results in a subtle form of ethnocentrism, denying Indigenous peoples the tools to assert and implement their local knowledge and epistemologies (Kirmayer, 2007; Hwang, 2005; Tait, 2008; Wilson, 2008). To some extent, these same colonialist assumptions are observed in the current edition of the DSM-V, which introduces a “Glossary of Cultural Concepts of Distress” and a “Cultural Formulation” as minor qualifications to what are assumed to be universal, culture-free diagnostic categories (Alarcon et al., 2009).

Research in psychological anthropology and cultural psychiatry has led to the assertion that the local cultural world—that is, our history of socialization and cultural learning, social institutions, values and localized practices—precedes the appearance of the individual, thereby patterning his or her developing biological and psychological processes (Eisenberg, 1995; Geertz, 1973; Turner, 1983). Culture thus creates alternative explanatory models or systems of meaning that dictate whether and how illness complexes are defined (Beiser, 2003; Ruiz, 2011).

Culture, from this perspective, is “less something which shaped an already existing natural phenomenon than the context in which any idea of illness was conceived” (Littlewood, 1990, p. 308). Moreover, as Alarcon et al. (2009) noted in their recommendations for the DSM-V, “the oversimplified framing of socio-cultural processes as merely epiphenomenal to mental disorders eclipses their constitutive role, resulting in essentialism, reductionism, and ethnocentrism” (p. 559). The response here, to positivist psychologists who support the classification systems of the DSM, is not simply that biomedicine has failed to understand cultural “beliefs” that motivate behaviour (Good, 1994), but that illness itself is relative to the cultural and moral milieu of a particular society. Any truly scientific psychology, Good (1994) argued, “must recognize the cultural relativity of pathology, rather than simply assume that our own illness forms are part of human nature and therefore universal” (p. 34). The core of the issue here, as Good continued, is that “illness representations or understandings of abnormality are not simply more or less accurate theories of a phenomenon external to culture, but that such representations constitute the very phenomenon itself” (p. 35).

From this view, Western diagnostic systems espoused in the DSM are not themselves culturally-free entities but rather explanatory models or “narrative frameworks” specific to Western contexts and cultural systems (Kirmayer, 2006). The most helpful notion of culture, Kirmayer (2006) suggested, “recognizes that psychiatry is the product of a cultural world, which leads to a critical appreciation of the implicit assumptions and historical grounding of our theory and practice” (p. 440). These “implicit assumptions” center on an overly materialistic, individualistic, and reductionist perspective of reality. Thus, the cross-cultural utility of the DSM, through its minimal attention to culturally patterned diversity in phenomenology and symptom presentation, is limited outside Western contexts within which the diagnostic

categories were developed (Alarcon et al., 2009; Gold & Kirmayer, 2007; Lewis-Fernandez & Kleinman, 1994; Littlewood, 2002; Lopez, & Guarnaccia, 2000; Mezzich et al., 1996). Viewed from this critical perspective, the DSM becomes a mere cultural document of a particular type.

It is important to stress that these reflections on the role of “culture” and the DSM categories of mental illness and disorder are again not meant to suggest that biomedicine and modern psychiatry do not have an important role to play in the maintenance of mental health in Belize. Further, it is not my intent to overly discredit the important biological aspects of illness conditions. As Beiser (2003) explained, “constraints on human physiology and cognitive process probably limit the varieties of human suffering to a finite number of symptoms and symptom complexes—many, if not all, of which may be recognizable across cultures” (p. 154). How similar do patterns have to be, then, before we can say we are talking about the same pattern? This remains a perplexing question not easily approached from a single perspective. Thus, it is important to be explicit about my rejection of simple either/or dichotomies that persist in contemporary literature regarding rationalist or universalist perspectives on the one hand, and interpretivists or relativists on the other. Indeed, as Good (1994) argued, “the juxtaposition of the analysis of psychopathology in relativist terms—as culturally defined abnormality, with culture bound disorders as the prototype—over and against the analysis of ‘medical’ disorders, in particular infectious diseases, in rationalist terms has served the field poorly” (p. 35).

When looking to the local *aj iloneleb*’ as a model to move forward, a pluralistic acceptance of multiple realities is seen. Collaboration and coordination between Q’eqchi’ healers and Ministry of Health PNPs is thus the goal. Such collaboration involves creating dialogues regarding both the conceptualization and treatment of mental illness and disorder. To move in this direction it is necessary to make sense of the claims of human biology and biomedicine,

while acknowledging the validity and veracity of local knowledge. The stance taken in this work, then, grants at minimum a “heuristic value” to the categories espoused within the DSM (Storch, Csordas, & Strauss, 2000), and, as such, the DSM categories are loosely compared to the Q’eqchi’ healers’ conceptions primarily to aid dialogues between Western psychiatric approaches espoused by the Belizean Ministry of Health and those held by Q’eqchi’ *aj iloneleb’*. The intention here is not to present DSM or biomedical perspectives as validation for the Q’eqchi’ understandings of mental illness and disorder. Rather, DSM categories are used as a loose “heuristic” to promote a common language for cross-cultural conversations and dialogue.

Primary Arguments and Research Objectives

Building on the notion that DSM categories are not culturally-free entities but rather explanatory models or “narrative frameworks” specific to Western contexts and cultural systems (Kirmayer, 2006), the primary argument throughout this dissertation involves the idea that Q’eqchi’ conceptions of mental illness and disorder engender a narrative framework or structure. In later sections, these are referred to as “narrative genres” of mental illness and disorder. As Wood (2004) observed in her study of the “diagnostic narrative within the DSM casebook,” any “medical diagnosis itself is both an interpretation, which thus holds hidden in its own shadow multiple alternative interpretations, and a trace marker for larger narratives with their own multiple histories, vocabularies, writers, and audiences” (p. 196). Psychiatric diagnosis, Wood (2004) continued, is “based on the reading and writing of patients through narrative” and “is a fraught, highly subjective process that draws on a wide range of culturally specific histories and contexts, some scientific, some popular, some literary” (p. 200). Thus, Wood (2004) concluded that psychiatrists, as Hunter (1991) and Montgomery (2006) observed with Western physicians, “are being trained as critics who must interpret a text. The text is the patient” (p. 218). Similarly,

throughout the current work and research with the members of the QHA, our research team developed a narrative understanding of mental illnesses and disorders.

According to Mattingly (1998) and Garro and Mattingly (2000), narrative allows us to come to terms with a problematic experience, to assist in the resolution of the mundane and exceptional challenges we face on a daily basis. As Gay Becker (1997) also proposed, narratives “emplot” or “domesticate” problematic experience by rendering it recognizable within a familiar and normalizing cultural worldview and ethos. In the case of illness experiences, narratives are constructed not only to describe and articulate the origin of suffering, but to imagine its location, source and culturally acceptable solution. Narratives about illness episodes, such as a “complicating factor” or an “unmaking of the life world” in Good’s (1994) terms, allow the individual to create a cognitive construction of order from the disorder and chaos that illness may bring.

As Mattingly (2010) and Garro and Mattingly (2000) contended, most narrative research of illness and healing in cultural psychiatry and medical anthropology has been about patient experiences. To look at and interpret the structure of healing epistemology through a narrative lens is, therefore, somewhat unique. Throughout this work, it is argued that “narrative” is the medium through which the epistemological structure of Q’eqchi’ medical reality is revealed and understood. The different mental illnesses recognized by the Q’eqchi’ healers represent varying narrative structures, genres, or “proto-typical plot forms” allowing the healers to locate a particular illness within a broad epistemological framework of known conditions (Good, 1994).

Following from this premise, a second argument of this research involves conceptualizing the work of Q’eqchi’ healers as “readers” of their patients’ “texts.” Through what is described as a form of “narrative reasoning,” the Q’eqchi’ healers come to know the details of a specific

illness episode, including what they can do to “further the plot” or assist in moving a patient toward some hopeful and expected outcome (Flemming & Mattingly, 2008). This process is detailed in later sections where it is argued that it is an empirical process that also relies on the medium of embodied “somatic attention” (Csordas, 1993, p. 135). Examining the nature of healing encounters in this way allows the concepts of “reading” and “text” to inform the overall analysis as well as highlighting the importance of what are later described as therapeutic intertextuality and texture.

From this perspective, the foregoing discussion centers on the epistemological structures of Q’eqchi’ healers’ conceptions of mental disorder and avoids issues of efficacy almost entirely. By building a relationship with the members of the QHA, the current research explores the development of illness categories, etiologies and therapeutic methods specifically pertaining to the areas of mental health in various contexts and times. This perspective seeks to communicate the extensive knowledge, experiences and testimonies of Q’eqchi’ healers rather than prove or disprove the scientific validity of the particular knowledge systems or therapeutic practices under discussion. This being said, however, from time to time when appropriate, contemporary scientific research is presented as a means of understanding and drawing out insights regarding the efficacy of Q’eqchi’ healing and epistemology.

A deeper understanding of the different narrative structures of mental illness and disorder held by the members of the QHA helps to build a foundation for future collaboration and dialogue between “traditional” Q’eqchi’ medicine and the Belize Ministry of Health. This deeper understanding of Q’eqchi’ mental illness and disorder can also foster the ethical and culturally appropriate treatment of Q’eqchi’ patients suffering from various forms of mental illnesses and disorders in southern Belize. Aside from documenting the conceptualization of

mental illness and disorders held by the QHA members, these are the major objectives of this research that take on a form of local advocacy. The intention is to demonstrate to the medical and psychiatric communities generally, or the Belizean Ministry of Health particularly, that Q'eqchi' healers and their knowledge are important factors in the primary mental health care in southern Belize and should be respected as such. The contemporary marginalization of Q'eqchi' medical practice and epistemology is largely the result of historical and political forces rather than efficacy (Ross, 2012). Thus, this work involves questioning the displacement of Maya medicine locally and “alternative” or traditional medicine more broadly within the Belizean and Central American landscape. Working under the auspices of the QHA, a final argument of this project is that a collaborative and dialogical approach to mental health care in Belize would be most prudent. At the same time, this research provides critical and constructive analysis of biomedical knowledge and practice amidst Indigenous communities in general or Q'eqchi' communities in particular. Developing a coherent understanding of Q'eqchi narrative structures of mental illness and disorder and the related epistemology of treatment approaches are important steps in these directions.

Research Paradigms and Indigenous Epistemologies

To develop the main arguments and objectives of this research, the following is grounded in and informed by what several scholars refer to as an Indigenous research paradigm (Battiste, 2000; Botha, 2011; Brant-Castellano, 2004; Bull, 2010; Cordero, 1995; Denzin & Lincoln, 2005; Kovack, 2010; Lavallée, 2009; Lincoln & González, 2008; Loppie, 2007; McClelland, 2011; Smith, 1999; Wison, 2008). According to Thomas Kuhn (1996), “paradigms” function as accepted patterns or models of engagement with the world that organize and define sets of appropriate questions to pose or problems to solve. The paradigm of any research approach,

therefore, shapes a project by outlining what is worthy of researching, what questions are to be asked, how they are asked, and how the data are analyzed (Smith, 1999).

According to Wilson (2008), what we might call an Indigenous paradigm necessarily involves multiple realities or a pluristic web of ontological perspectives, as espoused within a “social constructionist” research paradigm (Crotty, 1998). In this manner, one’s vision of reality is not something that is “out there” or external to the individual, but rather comprehended within the relationship that one has with that aspect of reality. In other words, it could be said that an Indigenous worldview or ontology *is* the relationships or sets of relationships that an individual or community holds. Therefore, Wilson (2008) suggested that reality is not grasped within material objects, but as a “process of relationships” and argued that an “Indigenous ontology is actually equivalent to an Indigenous epistemology” (p. 73) because “Indigenous epistemology has systems of knowledge built upon relationships between things, rather than on the things themselves” (p. 74).⁷

Several Indigenous scholars argued that research situated within a Western (i.e., North American and European) scientific paradigm, or the “Cartesian-Newtonian worldview” (Medina, 2006), embodies implicit assumptions that are inappropriate or even harmful when conducting research with Indigenous communities (Battiste, 2000; Crazy-Bull, 1997; Harvey, 2003; Ho, 1998; Wilson, 2008). Western scientific paradigms, although diverse, typically focus on the universal, objectivist, and radically materialist or reductionist aspects of reality. As such, Western scholarship and philosophy tends to—either explicitly or implicitly—compartmentalize

⁷ Wilson (2008) pointed out that in the Plains Cree language of central Canada there are significantly more verbs than nouns. Objects themselves are not often named. Instead, what they might be used for is described. For example, a chair becomes “to sit on” and a pen is “to write with.” Similarly, the Q’eqchi’ word for healer, *aj ilonel*, or spiritual guide, *k’atol xam*, describe the sets of relationships these individuals embody and maintain (i.e., the “one who sees illness,” or the “one who burns the fire” respectively). Thus, it is the relationship to the object that is central rather than the object itself. In contrast, the English language only requires one word to describe something (i.e., noun or pronoun), but many words to describe its use; the importance is placed on the singular object of reality rather than upon one’s relationship to that aspect of reality.

the world into mutually exclusive opposing forces: the dichotomies of science versus religion, reason versus faith, logic versus intuition, natural versus supernatural, material versus spiritual, secular versus sacred. The result is an overly materialistic worldview that emphasizes the importance of science, reason, logic, the natural, the material and the secular while ignoring or even denigrating the importance of religion, faith, intuition, the supernatural, the spiritual, and the sacred (Medina, 2006). Thus, the “worthiness” of a research program stemming from Western epistemological frameworks, as noted above, invariably conforms to subtly pervasive materialist standards, often marginalizing the role of faith, intuition, spirituality, or, more specifically for this research, Indigenous epistemologies.

Research programs with or on Indigenous communities that embody traces of Western scientific paradigms are susceptible to perpetuating colonial attitudes of oppression by implicitly marginalizing Indigenous knowledge and practices. Indeed, the imposition of Western epistemological frameworks on non-Western or Indigenous communities has been viewed critically as a kind of cultural imperialism or colonialism (Abdullah & Stringer, 1999; Battiste, 2000; Bishop & Glynn, 2003; Crazy Bull, 1997; Harvey, 2003; Ho, 1998; Howitt & Stevens, 2005; Hwang, 2005; Loppie, 2007).⁸ As Indigenous scholar Linda Smith (1999) argued

From an Indigenous perspective, Western research is more than just research that is located in a positivist tradition. It is research which brings to bear, on any study of Indigenous peoples, a cultural orientation, a set of values, a different conceptualization of such things as time, space and subjectivity, different and compelling theories of knowledge, highly specialized forms of language and structures of power (p. 42).

⁸ It could be argued that the analysis of Q’eqchi’ healing epistemology through a narrative lens follows such an imposition of “Western” paradigms. What I argue, however, is that the organization of medical reality through stories and narrative is adopted as an analytic lens because it is an Indigenous way of conceptualizing illness and organizing reality (Kovack, 2010; Loppie, 2007; Wilson, 2008).

Research carried out through “imperial eyes” assumes that Western theories of reality are the only ideas possible to hold, or as Smith (1999) continued, “certainly the only rational ideas, and the only ideas which can make sense of the world, of reality, of social life, and of human beings” (p. 56). With regard to practices of Western biomedicine in particular, several authors contend that if the integration between Indigenous and Western health care is ever to occur, it is necessary for Western practitioners and government health ministries to acknowledge that their beliefs and practices are deeply entrenched in a paradigm that excludes all but rational empirical thought (Duran & Duran, 2000; Hatala, 2008). The fact is that many Western academic disciplines (i.e., North American and European), such as biomedicine, psychology or anthropology, are saturated by paradigmatic thinking that is either antagonistic to other systems of knowledge or, as observed with the Ministry of Health in Belize, simply silent regarding the Indigenous knowledge systems that are different from its own.

According to the QHA members, these pervasive assumptions in “Western” thinking are problematic. The *aj iloneleb*’ in Belize agree with Maya scholar Carlos Cordero (1995) that within Western paradigms there seems to be an uncomfortable “emphasis on approaching knowledge through the intellect” and an untenable “separation of those areas called science from those called art and religion” (p. 30). Cordero observed that among Maya Indigenous epistemologies, knowledge is approached not only through the intellect and reason but also through corporeal sensuality and intuition. Various domains of knowledge are integrated so that medical science becomes both a religious and aesthetic enterprise. Thus, although the Q’eqchi’ healers value scientific research, they recognize this knowledge as only part of a larger story.

These critical notions of “Western” thinking have been commented on in cultural psychiatry, psychological anthropology and medical anthropology, especially research carried

out from critical interpretive (Lock & Scheper-Hughes, 1996) or critical phenomenological (Good, 1994) perspectives. This research has questioned uncritical “rationality” and Western paradigmatic assumptions of power and authority several years before Linda Smith (1999) made her arguments for an Indigenous research paradigm. Indeed, Byron Good (1994) acknowledged that “it is difficult to avoid a strong conviction that our own system of knowledge reflects the natural order...and that our own biological categories are natural and ‘descriptive’ rather than essentially cultural and ‘classificatory’ (p. 3). These deeply held assumptions, Good (1994) continued, “authorize our system of medical knowledge and, at the same time, produce profound difficulties for comparative societal analysis” (p. 3). Yet, Good (1994) went on to observe that an “empiricist theory of medical language” serves poorly for either cross-cultural research or for our studies of American science and medicine. After years of teaching, I am more convinced than ever that the language of [Western] medicine is hardly a simple mirror of the empirical world. It is a rich cultural language, linked to a highly specialized version of reality and system of social relations (p. 5).

Emerging in cultural psychiatry and medical anthropology are critical reflections on Western paradigmatic assumptions of rationality, materialism, and superiority as well as a counter-narrative regarding the cultural and political economy of hope and overwhelming optimism often associated with biomedicine and Western scientific thinking (Good, 2007). Because of the paradigmatic emphasis on material and mechanical aspects of illness and health, the so-called “biological gaze” that Nigh (2002) observed, contemporary biomedicine faces a growing number of criticisms: the ever-increasing costs of biomedical technology and treatments (Lock & Nguyen, 2010; Rapp, 2000); expanding conceptual, linguistic, and social gaps between patient and provider (Fadiman, 1997; Good, 1994; Harvey, 2008; Illich, 1976); common-but-deadly

procedural risks and intrusions (Lock & Nguyen, 2010; Martin, 2001); and the objectification and division of bodies (Foucault, 1973; Lock & Scheper-Hughes, 1996). Critical reflections of this kind, although operating from Western epistemological frameworks, are opening up dialogue on the possibility of interest in other rich cultural medical languages linked to versions of reality and systems of social relations distinct from Western paradigmatic assumptions. Thus, contemporary research and philosophical reflections in cultural psychiatry and medical anthropology are lending support for sought after dialogues between biomedicine and “traditional” healing by questioning assumptions within Western paradigmatic thinking and providing spaces for Indigenous medical practices and epistemologies to be consulted upon and heard.

The current research moves swiftly into this critical dialogue opened up by cultural psychiatrists, medical and psychological anthropologists, and Indigenous scholars. Therefore, ethically and culturally appropriate collaborative research with the Q’eqchi’ Maya peoples of southern Belize is carried out by acknowledging and embracing the value of Indigenous epistemologies. As such, it is not assumed a priori that the views or knowledge of reality expressed—implicitly or explicitly—by biomedical science or a Cartesian-Newtonian worldview have any more claims to truth than other views, for example, those expressed through Indigenous epistemology or worldviews. By working with the QHA members, it is recognised that an Indigenous research paradigm must be sensitive to multiple sources of knowledge: those which are “traditional” or handed down more or less intact from previous generations; those which are “empirical” or gained through careful observation and embodied practice; and those which are “revealed” or acquired through dreams, visions, and intuitions that are understood to be essentially “spiritual” in origin (Castellano, 2000). Thus, when Francisco explained how the

prayers he utters stabilize a patient's blood or that he communicates regularly with spirits through his dreams and embodied sensations, our research team respectfully listens and takes into consideration the healing epistemology expressed. The interest is not in studying the "beliefs" of some exotic cultural other (Good, 1994), but rather in the systems of knowledge that his stories and experiences reveal, the sets of relationships they embody, the medical imaginary they engender, and the insights to be gained into the nature of our shared reality.

Critically Engaged Moral Ethnography

Walking a research path from this epistemic position allows what could be called a critically engaged moral ethnography to flourish. Traditional ethnographic research typically involves the prolonged immersion of the researcher into a local setting to develop detailed descriptions and interpretations of social interactions or cultural practices (Evans-Pritchard, 1956; 1976; Geertz, 1973; Kleinman, 1995; Madden, 2010; Susser, 2009; Turner, 1967; Wolcott, 1995; Wolf, 2007). During the ethnographic work conducted from February to October 2011, data were generated through participation in the day-to-day lives of community members, conversations and interviews with Q'eqchi' healers and patients, and observations of clinical encounters (Dewalt, Dewalt, & Wayland, 2000; Jessor, 1996).

With regard to the ethnographic process, Csordas (1997), building on Geertz's (1973) original assertions, made two important points of clarification. First, Csordas suggested that the researcher is always both an author and an actor. This implies that the researcher's influence on the "other" being studied is not only inevitable but also necessary. Influence is inevitable in the sense that any study will impact the community being studied, but necessary because in order to study a community contact must be made. Secondly, Csordas (1997) argued that ethnographic research is an interpretation of an interpretation. Csordas proposed that when undergoing

ethnographic research, the “other’s” reflexivity should be acknowledged and that the researcher can only present an interpretation of their interpretations of their cultural practices. This interpretation of their own practices or “native exegesis” as Csordas put it, is an important source of data (Csordas, 1997, p. 61). One goal of the current ethnographic research, then, is to understand how the Q’eqchi’ healers’ interpret their social, spiritual or cultural practices—specifically those related to the conceptualization and treatment of mental illness and disorder—and then interpret or present those interpretations.

Additionally, Shweder’s (1996) “true ethnography” sought a balance between solipsism and superficiality in order to gain access to “other minds and other ways of life so as to represent what it is like to be a differently situated human being” (p. 17). Ethnographic research from this view seeks a “thick description” of the phenomena under study so to highlight the “other” in such a complete and detailed fashion that people can get a glimpse of those “others” so completely as if to know what it is like to be them (Geertz, 1973; Shweder, 1996). Solipsism is understood as the view that the only mental life people can ever “really” know is their own. In this sense, solipsism is strictly avoided in order to understand the lived experiences of others. Superficiality is also avoided in the sense that surface descriptions or mere physical associations limit access to the rich intersubjective realities of the Q’eqchi’ healers’ experiences and those of their patients. Detailed participant observations, participation, conversations and interviews were used to avoid superficiality and solipsism and in order to “get at,” describe, or become close to, specific aspects of Q’eqchi’ medical reality under study (Shweder, 1996).

To move forward from traditional ethnographic work, research with the QHA members carried out from Indigenous research paradigms involved a participatory consciousness. This consciousness ultimately built what Julie Bull (2010) called “authentic relationships,” that is,

communities and researchers collaborating in a co-learning environment in which mutual interests and agendas are consulted upon and enacted in the overall research process. A critically engaged moral ethnography—collaborating with Indigenous communities or otherwise—must foster such an “authentic” approach. As long as the knowledge, stories and experiences exchanged through the research process do not occur between equals, between friends, the historical legacy of colonialism, imperialism, subjugation and oppression can persist (Botha, 2011, Denzin, Lincoln, & Smith, 2008; Lavallée, 2009; Smith, 1999; Wilson, 2008).

The current ethnographic research was carried out amidst a critical-dialogical space where axiology was foregrounded during ethnographic encounters and researchers could re-negotiate “the role of spirituality in human inquiry” (Guba & Lincoln, 2005, p. 200). A core part of the research enterprise is the embodiment of the values and characteristics of humility, trust, generosity, patience and respect. Therefore, research ethics from within an Indigenous paradigm that inform participation, conversations, interviews, and observations aid researchers in building “authentic” friendships and relationships (Bull, 2010; Denzin, Lincoln, & Smith, 2008; Loppie, 2007; McClelland, 2011). Without this moral ontology, contemporary academic rituals such as gaining consent before interviews become empty and meaningless for those collaborating in a co-learning research environment. Respect for the members of the QHA is not just about being polite or obtaining permission to observe healing encounters. Rather, it is about listening intently and “participating” in day-to-day activities (Dewalt, Dewalt, & Wayland, 2000; Emerson, Fretz, & Shaw, 2001), participating with the individuals and communities most affected by the issues being studied. This critically engaged moral approach calls us to question our potential hierarchical position to our research communities, informants and topics.

Throughout the nine-month ethnographic research in the Toledo district of Belize, the role of advocate and activist emerged while working with Q'eqchi' healers, individuals and communities to improve conditions and gain the acknowledgement and respect from government authorities. In this sense, "participation" in a morally charged ethnographic project makes it impossible, as Susser (2009) noted, to study alongside community members who are, for example, becoming infected from a preventable disease without advocating for preventative resources. It is equally untenable to conduct ethnography about local medical practitioners or Indigenous healers that are being overlooked by Ministry of Health authorities without assisting in having their voices heard. In this sense, the current study focuses on "avenues of hope": local input by Victor Cal and the QHA members regarding the longevity and vitality of Q'eqchi' medicine in the face of ever-encroaching biomedical authority and neo-liberal ideologies; and local interventions to promote and sustain the knowledge and practices that foster and maintain mental health and well-being in Q'eqchi' communities. As Susser (2009) observed, "it seems essential that ethnography in such situations include intervention" and although "there is the risk here that one can make major mistakes and advocate for policies that backfire on the downtrodden," Susser argued that this is a risk "we all take as citizens of the world" (p. 14-15). Indeed, the implications of traditional medicine becoming more regularly in dialogue with the Belize Ministry of Health and its policies cannot be determined. Nor can the implications of formally documenting the conceptualization and treatment approaches of various mental health conditions recognized by the *aj iloneleb* be grasped fully. Yet, failing to move in these directions and face new challenges as they emerge is a scenario that the QHA members are not willing to consider.

It is in this way that a morally engaged ethnographic project aligns with a rich history of applied anthropology or anthropological advocacy (Cook, 2003; Hastrup & Elsass, 1990; Kedia & Willigen, 2005). Indeed, as Hastrup and Elsass (1990) described, “it should be stressed that in particular cases [of anthropological fieldwork], advocacy is no option but an implicit requirement of the social relationship established between the anthropologist and local people” (p. 301). From an Indigenous paradigm, this advocacy or application of the knowledge generated and systematized during research, however, is done through collaboration and consultation with the members of the QHA, where the knowledge, stories and experiences exchanged through the research process occur between equals and friends (Bull, 2010; Smith, 1999). Advocacy in this context is about working with and not about speaking for. As previously mentioned, the members of the QHA have requested and defined all aspects of this research, including the goals of establishing greater dialogues with the Ministry of Health in Belize. In this way, advocacy and research are constantly informing each other; research providing the grounds on which advocacy can take place, and advocacy providing the grounds on which “authentic” research can occur (Bull, 2010; Cook, 2003; Kedia & Willigen, 2005).

During fieldwork in Belize, I lived primarily in the larger southern capital of the Toledo District called Punta Gorda. Several additional overnight stays in the surrounding villages also occurred. Throughout the nine months in Belize, 94 semi-structured qualitative interviews lasting between one and three hours (Denzin & Lincoln, 2005; Rothe, 2000) were carried out with the six active members of the QHA on topics related to the epistemology, conceptualization, and treatment of mental illnesses and disorders (see appendix for semi-structured interview guide). Although following the general principles of qualitative research (Rothe, 2000), the semi-structured interviews were also influenced by Indigenous methodologies and research paradigms,

which involved a “conversational” approach (Denzin, Lincoln, & Smith, 2008; Kovack, 2010). As a research method, Kovack (2010) explained, “conversation is unlike standard structured or semi-structured conversations that place external parameters on the research participant’s narrative” (p. 94). A conversational method, she continued, is open-ended and “shows respect for the participant’s story and allows research participants greater control over what they wish to share with respect to the research questions” (p. 94). Thus, the 94 interviews were at times guided and semi-structured by our research team when attempting to grasp specific concepts or ideas, whereas at other times these interviews resembled more of a “conversation” and were “open” and “fluid,” allowing the members of the QHA to guide the questions asked and stories shared.⁹

Throughout this ethnographic project in Belize, our research team was also invited to observe 43 healing encounters with the permission and consent of the individuals and families involved. Depending on the circumstances, video recordings and photos were taken of the healing encounters. The observations and ethnographic encounters that occurred were at the discretion of the QHA members and the translators assisting with this project. As researchers, we did not always know or plan to observe a specific healing encounter. Rather, we were simply invited to participate at the healers request. At times we were relaxing in a Punta Gorda restaurant when a healer would find us and explain we needed to go with him to observe a patient healing. At other times several weeks would go by without a single invitation. It must be acknowledged, therefore, that the somewhat arbitrary invitations to observe a healing encounter

⁹ The term “research team” is used at certain times to reflect the notion that most research activities occurred with a team of individuals rather than a single researcher. Andrew Hatala, Thomas Caal and other Q’eqchi’ locals or interpreters as well as James Waldram and Victor Cal are primarily conceptualized as the “research team.” For the majority of the project conducted in 2011, Andrew and Thomas were the day-to-day members of the “research team.” There were occasions where Andrew was alone with one of the healers or where an interview was conducted with a patient in English. In these cases, “I” is used to refer to Andrew’s one-on-one conversations. In most other instances, “we” or “research team” is used to refer to the researchers’ actions.

determined the stories accessed and knowledge generated. It is possible that we were only invited to observe illness cases the healers felt our research team would find interesting. The discriminatory actions on the part of the healers and translators were not always clear. After each healing encounter that was observed, field notes were recorded to capture as much detail of the encounter as possible. Observational field notes were also recorded of various cultural events and informal conversations, as well as prolonged activities and ceremonies where one-on-one interviews were not feasible (Dewalt, Dewalt, & Wayland, 2000; Madden, 2010).

In addition to the healer interviews and ethnographic observations, 26 additional qualitative interviews were held with a few of the patients observed in a healing encounter in order to understand, in more detail, narrative accounts of their illness experiences (Good, 1994; Rothe, 2000). The patient interviews ranged in length from 15 to 45 minutes. Pseudonyms were used and no revealing information was portrayed in detailing the clinical observations.

All of the research interviews and conversations with patients and members of the QHA occurred in the Q'eqchi' language through a local Q'eqchi' translator. One main translator, language expert and cultural guide, Thomas Caal, worked with the QHA and the research project for the entire duration. In many cases, Thomas Caal also served as a cultural broker and ethical advisor to the research project by protecting the privacy and ensuring respect of the patients. There were times when Thomas determined it was not appropriate to observe a healing encounter or have a conversation with a patient for reasons not fully understood by our research team. In this respect, Thomas held considerable research power, acting as the ethical eyes and ears of the research project. Furthermore, Thomas was also extensively trained to write and read the Q'eqchi' language by the *Academia de Lenguas Mayas de Guatemala* (ALMG) (Guatemalan Academy of Mayan Languages). This locally operated, grass-roots Academy has standardized

the 21 different Maya languages spoken in Guatemala. For the current research, since Thomas was the main translator for the project, the standardized version of the Q'eqchi' language approved by the ALMG is used throughout.¹⁰ A glossary of basic Q'eqchi' terms and definitions follows in Appendix B to assist the reader.

In addition to Francisco's son Thomas, five other assistant translators, Rosy Maquin, Pedro Maquin, Domingo Acal, Federico Caal, and Lydia Saki, were involved with various aspects of the research process. Throughout this project, the research team from the University of Saskatchewan also assisted Thomas Caal and the other translators to build their capacity as local researchers. Each research interview with an *aj ilonel* or patient was recorded with an audio recorder and re-translated by a second Q'eqchi' interpreter and transcribed fully in order to capture the word-for-word translations of the *aj iloneleb'* as well as the onsite interpretations of the translators. In order to ensure precision during the translation work, second translations were carried out independently from the first. This translation process created question-answer quartets going from initial question in English, to Q'eqchi' question, to Q'eqchi' response, back to English answer. Throughout this work, only the Q'eqchi' healers' remarks are presented for clarity, succinctness, and overall coherence. It is important to note that communicating their perspectives of mental illnesses and disorders for the purposes of research was a new exercise for the Q'eqchi' healers. There was, therefore, many ambiguities involved in the translational aspects of this project. Having multiple translators and double translation techniques were used to mitigate this ambiguity to some degree. Although the discussions of Q'eqchi' mental illnesses

¹⁰ The *Academia de Lenguas Mayas de Guatemala* is a Guatemalan endogenous Maya organization that regulates the use of the 21 Maya languages spoken within the borders of the republic. It has expended particular efforts on standardizing the various writing systems used and promoting Maya culture by providing courses in the country's various Maya languages and by training Spanish-Maya or English-Maya interpreters like Thomas Caal. According to the ALMG, the Q'eqchi' language, sometimes incorrectly spelled Kekchi, constitutes its own sub-branch within Quichean-Mamean and is spoken by about 400,000 people in the southern Petén, Izabal and Alta Verapaz departments of Guatemala, and also in Belize by about 9,000 speakers.

and disorders are presented throughout in a format familiar to the Western audience, readers are reminded that even the best descriptions of Q'eqchi' medical knowledge will elude the subtly intuitive nature of Q'eqchi' cultural knowledge and diagnostic activities. The research and perspectives of the Q'eqchi' healers presented throughout are a necessary early step in understanding their knowledge from Western perspectives.

The entire interview, translation and transcription process generated over 900 pages of textual data from the 94 healer interviews and over 130 pages of textual data from the 26 patient interviews. Another 200 pages of observational field notes accompanied and helped provide contexts for the interviews and conversations with *aj iloneleb'* and their patients while also providing “thick descriptions” of the 43 healing encounters that were observed (Geertz, 1973). Based on the size of the data set and scope of this project, our research team decided to focus this project primarily on the healers' perspectives, knowledge and experience. Thus, the patient interviews are drawn on in the following analysis only to a limited extent and will appear primarily in separate publications that emerge from this project.

During the first look through the data (i.e., aggregate transcripts and field notes), themes were highlighted and separate analytic files were constructed (Rothe, 2000). The analytic files included any data detailing specific areas of interest (i.e., Q'eqchi' cosmovision, diagnosis, etiology, treatment approaches, different mental illness conditions, and case studies of each healing encounter). Once breaking the total transcripts into separate analytic files, the data were read through several more times to capture the main ideas, highlight them in the margins, and create concise phrases that capture, as much as possible, the essential quality of the section, theme or concept being expressed. This first stage of analysis ultimately transformed the entirety of the analytic files into a series of interrelated themes. Separate analytic files were then

constructed on additional themes of interest (i.e., pulsing of the blood, prayer, *maatan*, reading of *copal pom*, Q'eqchi' ceremony, Q'eqchi' "metaphysiology", bodily sensations, etc.).

Following this, the second phase of analysis consisted of going through the compiled list of emergent themes and analytic files by examining connections between them. Analytic and theoretical ordering of concepts then helped to make sense of the connections between and among different themes (Rothe, 2000; Smith & Osborn, 2003). After making initial connections between the generated themes, tables were created in order to visually examine the themes and main ideas in a coherent order. Appendix C details a general thematic map of Q'eqchi' healing epistemology, and each chapter or section within each chapter details a specific concept or theme while within the framework of the overall arguments regarding the narrative structure of Q'eqchi' medical reality. What emerged from this analysis was a way of describing Q'eqchi' mental illness and disorder in narrative terms, and only a selection of the data that illustrates this conclusion is presented in this dissertation. Condensed versions of themes and narrative structures for each mental illness condition are presented in Tables 5-9 in Chapter Three.

All aspects of this research were approved by the Research Ethics Board of the University of Saskatchewan and the Institute for Social and Cultural Research in Belize. Oral consent was obtained before all interviews and healing observations. Appendix E contains the oral consent protocol guide.

During the reporting and analysis of all research data, the Q'eqchi' healers requested that their full names be used. In fact, the *aj iloneleb* found the idea of "pseudonyms" to be quite foreign since part of their request for research was to document their stories, experiences and knowledge for posterity. The Q'eqchi' healers want to be remembered for who they are. They are not interested in keeping their identities a secret from the scientific or the local communities.

Finally, it is important to note that the validity of ethnographic research employing qualitative data, especially as carried out from Indigenous research paradigms, is measured on different grounds as compared to traditional quantitative or positivist psychological research. From an ethnographic perspective, the validity of the knowledge gained from a study is understood with phrases such as “credibility”, a “ring of authenticity”, or “plausibility” (Jessor, 1996, p. 5). Moreover, “plausibility” within ethnographic findings occurs in direct proportion to the extent that the researchers get “closer” to the experiences under study by virtue of observing behaviour in the actual environments and letting people explain their experiences, interpretations and meanings in their own words (Geertz, 1973; Becker, 1996). Furthermore, work that is based on “experience near” observations of a wide variety of matters that bear on the research questions are more valid than work that advances conclusions made from more remote kinds of observations (Jessor, 1996; Madden, 2010; Waldram, 2012). Overall, then, in contrast to quantitative research in fields such as psychology, the goal of ethnographic studies is not to “prove” the existence of a particular relation between variables or the efficacy of a specific treatment modality, but to show how things “hang together in a web of mutual influence of support, to describe the connections between the specifics” (Becker, 1996, p. 4).

Chapter Summaries and Overall Plan

Generally speaking, local practices, systems of knowledge or intricate webs of social relations endure because they contain social power, they fulfill needs and yield benefits of some kind (Ross, 2012). Q’eqchi’ medicine, embracing the diversity of epistemological structures and practices therein, endures because of the various cognitive, emotional, social, biological or spiritual benefits that are derived from its use. Such patterns of benefit may not be overtly efficacious in a statistically or strictly biomedical sense. As long as a healing approach endures

and becomes perpetuated, it has significance, merit and value from social, psychological or anthropological perspectives. Although sustaining various local adaptations over the years, Q'eqchi' medicinal practice generally, and the local maintenance and promotion of mental health particularly, has endured. The following chapters document and clarify the various aspects of the work of the *aj iloneleb'* of southern Belize and the stories, knowledge and experiences of the QHA members and their patients.

Chapter Two contains a deeper exploration into the role of “cosmovision” or Q'eqchi' ethos and worldview. This chapter provides a background and context to understand factors that impact the diagnosis, conceptualization, and treatment of mental illness and disorder in Q'eqchi' communities. Questions regarding how illness comes to have meaning, “of how reality (not simply beliefs about it) is organized and experienced in matters of sickness and care” (Good, 1994, p. 63) are explored. Several analytic concepts functioning as “formative processes” or “interpretive activities” are presented (Cassirer, 1950), including: the locally informed notion of relationality; moral economy of permission; and the concept of *maatan*. In addition, the Maya book of creation (The *Popul Vuh*) and the contemporary role of the Maya calendar, particularly as it is used in delineating the appropriate days and times for various healing ceremonies or procedures, are briefly discussed. Q'eqchi' concepts of “Metaphysiology” are also detailed to gain an appreciation for and deeper understanding of the local conceptions of the person, including mind, heart, spirit and body. The concepts reviewed in this chapter are central to Q'eqchi' cosmovision and form the background against which local experiences and narratives of mental illness and health can be appropriately understood and interpreted.

In Chapter Three the various illnesses of the mind that are recognized and understood by the Q'eqchi' healers are described. This chapter is, in many ways, the core of the text and a point

of departure for discussions regarding the relation between Q'eqchi' conceptions of mental disorder and those recognized by Western psychiatric nosology (the DSM). In this chapter the primary argument of the dissertation is outlined and expanded: there are narrative structures or "genres" to the Q'eqchi' healers' conceptualizations of mental illness and disorder. Four broad "narrative genres" are outlined showing how 17 different mental illness conditions recognized by the members of the QHA fall under one of these larger narrative structures. Through a focus on the "Childhood and neurological disorders" narrative genre, how the general "narrative genres" of mental illness guide clinical interactions between patient and healer is demonstrated, how they "emplot" or "domesticate" patient experiences while directing therapeutic encounters to some hoped for and imagined future (Becker, 1997; Mattingly, 1994).

In Chapter Four the "Fright" narrative genre is detailed along with a case of *kaanil* or "soul loss" to explore how the *aj iloneleb'* negotiate the general narrative structures of an illness condition with the particulars of a specific case. The process of "clinical judgement" or cultural logics that *aj ilonel* employ during the treatment of mental illness and disorder are described. It is argued that an interpretive, hermeneutic process of dialogically "reading" various "texts" that arise during clinical encounters forms the basis of the healers' clinical judgement or "narrative reasoning" (Hunter, 1991; Montgomery, 2006). This chapter illustrates how the Q'eqchi' healers draw on several distinct "texts" in order to "enfold" a specific case within the known structures of mental disorder or "narrative genres." Building on Mattingly's (1994) work, this is outlined as a process of "therapeutic emplotment."

Through an analysis of the "thinking too much" narrative genre and a case of *rahil ch'ool* or depression, Chapter Five examines the relationship between embodiment and narrative. By exploring how the broad "narrative genres" of mental illness and disorder are, for the Q'eqchi'

healers, improvised and embodied, the focus is on the role of the “body” in Q’eqchi’ healing practice. Unfolding within a broad paradigm of embodiment (Csordas, 1990), this chapter explores how the body as a site of knowledge and perception aids in the “reading,” interpretation, and “emplotment” of various “texts” that emerge during clinical encounters.

Chapter Six explores a case of suspected *rilom tzuul* that falls within the “spirit attack” narrative genre. Rather than showing a smooth and uncomplicated diagnosis and treatment of this case, however, this chapter explores the disruptions that can arise when a condition fails to narratively “fit” within the healers’ genres of mental illness and disorder. The focus is on diagnostic complications, on how the healers move between and adapt treatment approaches when therapeutic interventions appear ineffective. In the end, through the detailed analysis of a single case, it is revealed that what was originally thought to be *rilom tzuul* was actually a case of AIDS, a “new” disorder not fully integrated into the *aj iloneleb*’ narrative structure of illness and disease. Thus, this chapter also deals with the integration of “new diseases” and how the narrative genres may evolve over time based on the different cases that emerge during their services as local healers.

The concluding chapter is a synthesis of previous discussions and arguments which brings back notions of dialogue with the Ministry of Health in Belize. Overall, it is hoped that by reviewing these chapters the reader gains an appreciation for and understanding of illness categories, etiologies and therapeutic modalities used by the contemporary Q’eqchi’ *aj iloneleb*’ to treat various mental illnesses and disorders. Perhaps more important, it is also hoped that the Belizean health authorities come to respect and nurture the valuable resources latent within the deep recesses of this country’s diverse landscape: the local or traditional healers.

CHAPTER II: Q'eqchi' Cosmovision

Early one morning, Francisco, Emilio and our research team made our way through the winding dirt roads of the Maya Mountains in southern Belize. On Emilio's signal, the truck slowly rolled to a stop on the side of the dusty road. We then walked for nearly thirty minutes, with machete in hand, on a thin farmer's path through the dense bush and corn fields that littered the area. The limestone mountain before us grew closer; we were now being enveloped in its shadow. Few words were exchanged while listening to the cacophony of insects and birds. Turning sharply off the small path, we began the modest hike directly up the face of the mountain, grabbing thick tree roots and firm stones to aid in our ascent. The cool mountain breeze emanating deep from the belly of the cave welcomed us as we reached the mouth, about fifty meters above the corn fields below. Resting at the entrance to the cave, Emilio, elated to have guests at this sacred place, explained the history of the cave, its use and significance.

As the sweat slowly beaded from his forehead, Emilio described how he had been coming to this cave alone and with patients for over fifteen years. "It is a special spot to the Mayas," Emilio said with a gentle smile, "a place to offer prayers to the spirits of the Mountains and the Valleys, to ask for forgiveness, a place to ask *Qaawa'* [Creator God] for permission in what we do; a place of offering thanks to the earth for all the blessings that we have."

Emilio went on to explain how, within this cool dark cave, he asks for permission before picking the herbal medications he uses in his healing work; for assistance and power to heal patients; and for the knowledge and abilities to do both. Emilio also shared stories of patients that came to the cave for specific healings and was eager to point out the hundreds of little pieces of coloured cloth and paper that were placed in the cracks of the limestone walls; bright blues, shimmering pinks, lush greens and deep reds littered the cave entrance. These prayers and

offerings of thanks to Emilio and his brother Francisco were from the numerous patients they worked with throughout their many years as *aj iloneleb'*, which, in a way, formed a catalogue of the people they assisted over the years—a beautiful aesthetic symbol and a testimony to the importance of their work.

Following this brief introduction to the history and use of Emilio's cave, the cool breeze lured us inside. Moving forward, the light from the hot day quickly escaped us. We relied on the light from Francisco's candle to lead our way. About four meters high and three meters wide, the cave could easily accommodate our movement and the gatherings of a few large families. The four of us continued back into the cave for about thirty feet breathing in the cool mountain air. We then stopped at what appeared to be an arranged circle of stones in two separate layers. The two layers of the circular fire pit stood about half a meter above the cave floor and were roughly a meter in circumference. The bottom layer was old stone that seemed to arise out of the bottom of the cave. Later, when detailing more about the cave, Emilio suggested that this spot was frequented by ancient Mayas who would come here to similarly offer thanks and praise to the Mountain spirits and Creator. Placed on top of this old layer were a few loose stones that seemed to be gathered from the surrounding area, possibly arranged by one of the brothers—a visual connection between past and present.

Francisco and Emilio immediately placed several candles in four piles, one for each direction, around the inside edges of the stone circle. Satisfied with their placement, Francisco then arranged two candles in the middle of the stone fire pit and lit the other four areas of candles. The cave gradually became more visible as the fire grew and flickered in the subtle mountain breeze. Now visible, the roof of the cave and surrounding walls were stained black

with the thick soot from the billowing smoke that rose steadily from the flickering fire, as it has done for tens, if not hundreds, of years.

After the candle fire seemed to be large enough and the melting candles began to merge into one, Emilio, with candle in hand, began uttering soft words in Q'eqchi', prayers and offerings of thanks:

Now we'll pray; calling on the four corners of the earth and the saints. Now we're asking for protection so that no obstacles will be in our way and so we can move freely and safely. We ask on the Valleys and Mountains to help and now we'll offer a payment. This is what we offer, for you look after the people wherever they go. If there are traps in the way, allow them to pass over it safely. God help them. I'm asking you for your help.

Emilio stood three feet from the smouldering fire and offered more words of praise and thanks. Francisco was still tending to the fire, but then, when satisfied, joined his brother in what came to be a harmony of simultaneous prayers, overlapping words and gestures, barely contained within the reverberating walls of the limestone cave. After a few moments, Emilio got down on his knees; we followed. With one hand holding the candle, Emilio's other hand rested on the outer rim of the circular stone structure. Francisco continued to offer prayers beside him. Emilio held in his right hand an unlit white candle; his brother held in his right hand a lit candle and both prayed simultaneously asking for thanks and permission from the Mountains and the Valleys to continue with their work and service. The word "*bantiox*," meaning "thanks" in Q'eqchi', came repeatedly from their mouths.

After several minutes of saying prayers with the candle in hand, Emilio placed his candle in the fire. With two hands moving with vibrant gestures, he continued to offer words of thanks. Francisco, still grasping his candle, continued as before for a few minutes, then placed his candle

into the fire. After all visible candles were smouldering in the fire, Francisco pulled from his healing sack a small bottle of rum. He raised it above the fire, as if to show what he had, and with one finger covering the top so to control the amount of liquid emerging from the bottle, proceeded to spray it around the fire pit with a shaking motion of his right hand. Francisco repeated this offering in the four major directions of the circle fire. Emilio watched intently. As Francisco seemed to finish with the rum, Emilio bent down and kissed the rim of the circular stone pit, while taking the rum from his brother and continuing a similar motion. Emilio, with finger on top, sprayed the small alcohol container in a counter clockwise circular motion around the entire edge of the fire. When finished, Emilio passed the bottle back to his brother and again kissed the top of the circular stones. The bottle then disappeared back into Francisco's healing sack while the two brothers continued their prayers and words of offering and thanks. After a few more moments, Emilio and Francisco appeared satisfied with the process and rose to their feet, a signal to us that their work in the cave was, for now, complete.

Cosmovision as a Formative Process

Throughout history, individuals and communities have developed visions of the world around them that are shaped by local ecology, history, language and interactions with neighbouring peoples and ways of life. Like Thomas Kuhn's (1996) notion of "paradigms," these visions, views, and perspectives of the world function to provide patterns, norms or acceptable models of and for engagement with the world. These models organize and define the deepest questions to pose, values to uphold, stories to tell, worthwhile pursuits, psychological character and community social structure. In various cultures and localities, human beings maintain cognitive orientations that allow, as Hallowell (1960) observed, "order" and "reason" to prevail over chaos. There are, as Hallowell continued, cultural logics, basic premises and principles

implied within a people's orientation to and vision of the world, "even if these do not happen to be consciously formulated and articulated by the people themselves" (p. 20).

Describing further these aspects of people's visions of the world, Clifford Geertz (1973) drew on the term "worldview" to signify the cognitive or existential elements, "their picture of the way things in sheer actuality are, their concepts of nature, of self, of society...their most comprehensive ideas of order" (p. 127). As well, Geertz referred to "ethos" to reflect the moral, aesthetic or evaluative elements, "the tone, character, and quality of their life, its moral and aesthetic style and mood; it is the underlying attitude toward themselves and their world that life reflects" (p. 127). Worldview thus depicts the ontological assumptions that a community may hold, the presumed facts and structure of reality, whereas ethos is the approved style of life, a mode of being expressed by or normalized within a particular vision of reality. In other words, Geertz suggested that the embodied practices of a particular community (i.e., their rituals, religious or spiritual performances, or normalized social interactions) and the situated knowledge of a particular community (i.e., their concepts of time, space or persons, relations between people and the cosmos, or subjectivity) mutually confirm one another:

The ethos is made intellectually reasonable by being shown to represent a way of life implied by the actual state of affairs which the worldview describes, and the worldview is made emotionally acceptable by being presented as an image of an actual state of affairs of which such a way of life is an authentic expression (Geertz, 1973, p. 127).

Thus, when Emilio and Francisco move within the cool bowels of a limestone cave to supplicate to the spirits of the Mountains and Valleys, one catches a glimpse of not only their assumptive structure of reality, but also their deep-seeded moral values, their aesthetic sensibilities and approved styles of life.

For Francisco, Emilio, and the other *aj iloneleb*’ in the Q’eqchi’ Healers Association, their worldview and ethos centre on a complex network of relationships that include the interpersonal, intrapersonal, environmental, cosmological and spiritual facets of life. It could be said that Q’eqchi’ ontology *is* the relationships or “process of relationships” engendered through their vision of the world. In this way, contemporary Q’eqchi’ concepts of nature, of personhood or society, their perspectives of order and disorder, their ways of perceiving, interpreting, remembering, or creating stories about happenings in the world, as well as their tone, character or moral and aesthetic style and mood, in one way or another, pivot around a locally informed notion of relationality, what Molesky-Poz (2006) referred to as a “culture of reciprocity” or a “relational complementariness” (p. 42-44).

Ethnographic fieldwork among Q’eqchi’ healers in southern Belize revealed that the complex network of relationships informing their vision of reality is far from anthropocentric. Rather, the cosmos or spiritual worlds are often the key referent. Thus, “cosmovision” is the term typically used to describe the worldview and ethos engendered by Maya communities; a vision underpinning psychological, ontological, epistemological, moral and aesthetic realities.¹¹ Q’eqchi’ cosmovision is therefore not only a medium of perception, it is a medium of experience, a mode of engagement with the world in which human and spiritual reality are deeply interrelated. As Molesky-Poz (2006) described,

Maya link cosmovision to spirituality, or say that their worldview is found within Maya religiosity. We can infer that the term Maya cosmovision has an inevitable ontological or

¹¹ The term “contemporary” is often used in the following presentations of Q’eqchi’ cosmovision in order to situate the discussion in the present context of the Q’eqchi’ healers that participated in this study. The perspectives of cosmovision presented throughout are primarily the views of the Q’eqchi’ healers. The contemporary perspectives of the Q’eqchi’ healers are also compared to and contrasted with previous ethnographic literature with Maya peoples. As mentioned in Chapter One, this study honours and envisions the fluid and evolving nature of culture, including the concepts of worldview and ethos (i.e., cosmovision). Thus, readers are urged to interpret the following discussions of Q’eqchi’ cosmovision as the contemporary perspectives of the Q’eqchi’ healers in this research grounded in their social, historical and political contexts.

religious aspect, however implicit, that expresses the “lived” experience of Mystery from a human perspective situated in historical experience, struggle, and gratitude (pp. 44-45). The locally informed notion of relationality adopted among Q’eqchi’ communities (i.e., relations between individuals and a kind of “Mystery” or other-than-human personalistic realm) shapes the assumed structures of reality (i.e., the facts of the world) and guides and informs the approved aesthetic styles of life, offering a formative set of practices “through which Maya feel, think, analyze, understand, and move reciprocally in the cosmos” (Molesky-Poz, 2006, p. 35).

This chapter focuses on how contemporary Q’eqchi’ cosmovision constructs the medical “objects” to which *aj iloneleb*’ of southern Belize attend and the way in which their vision of the world and approved styles of life become the “formative processes” that shape the culturally distinctive narrative structure of their medical knowledge (Cassirer, 1950; Good, 1994). Rather than “belief” as a cultural category, the focus here is on the “interpretive activities” of Q’eqchi’ cosmovision through which the fundamental dimensions of reality—and especially medical reality—are “confronted, experienced, and elaborated” (Good, 1994, p. 69). The questions asked in this chapter are: How are the “objects” of Q’eqchi’ medical attention constituted in contemporary healing practice and discourse? What are the “interpretive activities” that are at work in Q’eqchi’ cosmovision and how are nosological systems constructed through such activities? How does Q’eqchi’ cosmovision impact the epistemological structure of medical reality? And how does cosmovision inform narratives of mental illness and disorder?

To understand and appreciate Francisco and Emilio’s movement in the limestone cave, to examine their healing work as well as their stories of illness and disease, a few “formative processes” or “interpretive activities” are illustrated (Cassirer, 1950). Although the topic of Q’eqchi’ cosmovision, both historical and contemporary, is vast and deserving of more detailed

descriptions than can be offered here, four prominent aspects for the members of the Q'eqchi' Healers Association are presented. These include: (1) a relationship to the Mountains and Valleys; (2) a moral economy of permission; (3) the concept of *maatan* or one's "gift" and day of birth; and (4) "metaphysiology" or the concept of personhood. It is argued throughout this chapter that each of these aspects of Q'eqchi' cosmovision are important factors that influence the interpretive structures of Q'eqchi' medical reality in some way and shape the developing narrative structures of Q'eqchi' mental illness and disorder.

Concerning the Mountains and the Valleys

The more deeply perspectives of Q'eqchi' cosmovision are grasped, the more it is realized that, like Hallowell's (1960) observations among Canadian Ojibwa communities, "social relations" between human beings and other-than-human "persons" are of central importance (p. 23). Foremost among these relations for *aj iloneleb'* of southern Belize are the trinitarian connection between *Qaawa'* (creator God), the spirits of the Mountains and the Valleys, and humanity. Emilio detailed the complex connections between *Qaawa'* and the spirits of the Mountains and the Valleys:

Qaawa' is God with powers beyond this world. The spirits of the Mountain and Valleys are beings who take care of the animals, trees and the resources contained within the jungle and our natural environment. *Qaawa'* looks after the people as do the Mountain and Valley spirits. The two beings are *Kojaj* and *Itzam*. These two powers give us our life because that's what we depend on and that's where the animals live and natural resources are. They both have power which protect us, but *Qaawa'* gives us our life.

As the conversation unfolded, Thomas clarified that *Kojaj* and *Itzam* are the names given to the respective spirits of the Mountains and Valleys. "They are a couple," Emilio added,

The male is *Kojaj* and the female is *Itzam*. For our healing work, or when we plant our crops, we do *mayejak* [ceremonies or rituals] to them for permission and we request that the animals or birds do not destroy the plants. They are the ones that guard the animals. That's why we offer them the food, drink, *copal pom* and candle; to protect our plants and crops. That's the way it is. Everything is paired off, the sun, the moon. That's the way the Maya calendar and history is.

For the Q'eqchi' *aj iloneleb'*, *Qaawa'* signifies an overarching singular creator God "with powers beyond this world" who is responsible for all life on Earth, including other kinds of spirits. The earth is a territory maintained by the owner, *Qaawa'*, who, in a sense, assumes ownership of the land and everything on its surface. *Qaawa'* is thus similar to notions of a Christian God or Islamic Allah who are responsible for the creation of reality, being exalted above or distinct from that reality, while maintaining a continual relationship with creation. This perspective of Q'eqchi' cosmovision envisions that a sacred order exists in the world, that a spiritual world permeates the human and natural order. The view is that, since the earliest days, there has been, and still is, important communications occurring between humans and the realm of the spirits (Thompson, 1972; Watanabe, 1992). This is a perspective that differs from notions of radical separations between the secular and the sacred, the material and spiritual.

The spirits of the Mountains and the Valleys, in a way, act as God's representatives or stewards on earth, looking after the natural resources. These spirits are conceptualized within a broad notion of Q'eqchi' other-than-human "persons" (Hallowell, 1960). They are part of the community and hold relations with individuals who act as if they are dealing with "persons" who understand and respond to human attempts at communication and are volitional in their own right. "Those spirits are in charge of all life around us," Lorenzo suggested.

The spirits of the Mountains and Valleys, also referred to during discussions as *tzuul taq'a*, or simply the “mountain spirits,” are reminiscent of other Indigenous concepts like Mother Nature or Mother Earth, symbolized by their role as nurturers or providers of life. Although working in consort, *Qaawa'* or God, being the owner of all the land, maintains a distinguished position above and beyond the spirits of the Mountains and Valleys. Manuel Choc explained that “God is like a superior King. You ask permission from Him first. Following this you ask the Mountains and Valleys. When you do that,” Manuel continued, “God is happy with us and He knows we’re doing the right thing. The Mountains and Valleys are like God’s secretary. They are the ones that help out in carrying God’s work on Earth and they even ask God to help us on their behalf.” Similarly, Francisco related, “You need to ask permission from God first, then to the Mountains and the Valleys,” and, “in the healing work you first pray to God, then to the Mountains and Valleys.” A hierarchical relation between *Qaawa'* and the spirits is observed, each holding a distinct position while preserving an intimate connection.

The Mountains and the Valleys that envelope southern Belize are also, in a way, sacred symbols to the local *aj iloneleb'* and Q'eqchi' communities. These symbols demonstrate, as Geertz (1973) described, a “meaningful relation between the values a people hold and the general order of existence” (p. 127). Sacred symbols, Geertz continued, “Relate an ontology and cosmology to an aesthetics and a morality: their peculiar power comes from their presumed ability to identify fact with value...to give to what is otherwise merely actual, a comprehensive normative import” (p. 127). Giving us a sense of this normative import, “Everything is paired off,” Emilio explained. In this way, the Mountains and Valleys, *Kojoj* and *Itzam*, or the male and female aspects of reality, are “forms” or “categories” of imagination; the duality they embody has become a “structural dominant,” giving form to the approved styles of life, assumptive

structure of reality, moral values, aesthetic sensibilities, dreams, and narrative myth (Cassirer, 1955; Jung, 1957, p. 845).¹² The complementary physical nature of the Mountains and the Valleys inform and reinforce the principle of duality embedded within these perspectives of Q'eqchi' cosmovision while at the same time acting as ecological symbols or “landscape archetypes” (Amita, 2006; Nash, 1997).

Natural patterns and symbols evoked by geological landscapes infuse virtually every facet of a people's intersubjective experience and the stories they tell about that experience. The term “landscape archetypes” alludes to the interrelatedness between the outer and inner worlds and between psychology and ecology. Through time, the local landscape impresses its shapes and patterns upon the human psyche, thereby infusing the social customs, myths, religious practices, and narratives of a people with the values and meanings that come to be associated with the local ecological symbols (Cajete, 1994; Nash, 1997). Geological formations like the breathtaking valleys and mountains of southern Belize are linked to an ontological and aesthetic envisioning of sacred space, a relationship between humans, the earth, and *Qaawa'* the Creator. As Cajete (1994) suggested,

The archetypes—being born from the earth of a place, and the participation of earth spirits in human conception—are universal among Indigenous people. This perception is reflected throughout the myth, ritual, art, and spiritual traditional of Indigenous people because, in

¹² As Tedlock (1985) also observed, the Maya book of creation, the *Popul Vuh*, emulates this principle of duality as manifest in the dual creators, “Heart of Heaven” and “Heart of Earth,” the latter being understood as an immaterial, incomprehensible energy and the former being the materialization of that energy in creation. This duality is again observed through the adventures of the hero twins, *Junajpu* and *Xb'alanke*, who together defeat the Lords of *Xib'alb'a* (i.e., the underworld) in the traditional Maya ball game (p. 341). For this reason Tedlock (1985) argued that multiples of two, and in particular the number four, are prominent in Q'eqchi' cosmovision and symbology. The four cardinal points, the traditional Maya cross, the first four women and men from the *Popul Vuh* narrative, and the four colours attest to this observation.

reality, our development is predicated on our interaction with the soil, the air, the climate, the plants, and the animals of the places in which we live (p. 83).

Cajete (1994) went on to develop the concept of “geopsyche” used to describe the dialogical relation between the local landscape and the human psyche. He suggested that when people live in a particular place for long periods of time they physically and psychically take on or mimic the characteristics of the landscape. Thus, Cajete (1994) argued, this is when “the development of mountain people as distinct from desert people and as distinct from plains people begins to unfold” (p. 84). In each place they inhabited, while being nurtured over generations, Indigenous peoples learned the subtle, but all important “language of relationship” (Cajete, 2000, p. 178), creating a sacred intimacy with each place, its animals, plants, and local ecology.

Emilio and Francisco’s movement within the limestone cave is recognized as a localized ecological language, a “language of relationship” embodied in the tone, gestures, sentiments, and epistemological structures of contemporary Maya cosmovision. As such, *aj iloneleb*’ visions of the world engender an intimacy between the people and the environment, blurring the lines between the earth, its personalistic spirits, and the Creator. In nearly all that they do, the Q’eqchi’ healers in this research humbly asked permission from the spirits of the Mountains and Valleys and from God. In this way, they reinforce their “most comprehensive ideas of order” and display their “underlying attitude toward themselves and their world that life reflects” (Geertz, 1973, p. 127). “With practicing and appreciating our place that is around us, our environment, forest, mountains, plants,” Francisco explained, “we have to ask blessings to all the spirits for us to move among them peacefully; that nothing should affect our lives.” With these requests and offerings, Francisco continued, “that we make to the spirits of the Mountain and Valleys, to God, and spirits of the different things, that is how we can avoid being affected negatively in our lives.

This is how we have the ability to do work as healers.” As we see here, Q’eqchi’ cosmovision involves not only a notion of “spiritual” relationality among humanity, *Qaawa’*, and the spirits of the Mountains and Valleys, but also a sacred “material” relation with the local ecology, the landscapes of the mountains and valleys.¹³

In the *Popul Vuh* (the Maya book of creation), the dual Creators, “heart of heaven” and “heart of sky” say to each other, “Let’s make humans to be the providers and nurturers.” (Tedlock, 1996, p. 57). In this way, Maya mythology and narrative history naturalize humans’ guardianship over the Earth. Later in the Maya creation narrative the dual creators discuss the importance of making offerings to nurture and build a relationship between themselves, the earth and the spirits while describing how the first humans made aromatic offerings of *copal pom* to honour the first dawn, “crying sweetly as they shook...the precious *copal*” (Tedlock, 1996, p. 161).¹⁴ Today, this aesthetic style of life continues among local *aj iloneleb’* and Q’eqchi’ communities. Emilio exemplified in the previous dialogue, “we do *mayejak* [ceremonies or rituals] to them [spirits of the Mountains and Valleys]...they are the ones that guard the animals that’s why we offer them the food, drink, *copal pom* and candle, that’s the way it is.” Q’eqchi’ *mayejak*, from this perspective, are a contemporary “language of relationship.” This is the “visible activity of the reciprocal relation in which persons maintain connection and harmony” (Molesky-Poz, 2006, p. 44).

In *mayejak*, different elements come together and, by reducing the space between things and between people and their environment, relationships are strengthened and fostered (Wilson, 2008). *Mayejak* in Maya cosmovision acts as a kind of attunement process. Such attunement, as

¹³ The “spiritual” and “material” aspects of these relationships are deeply connected, which together allude to or are suggestive of a human obligation to perform ceremony or make offerings in order to foster or develop relationships with the earth, *Qaawa’*, and the spirits of the Mountains and Valleys.

¹⁴ *Copal pom* is a Q’eqchi’ form of incense used in ceremony and healing encounters. It is explained in more detail in Chapter Four.

in musical instruments, refers to forming an accord, which acts between individuals, the environment, the spirits of the Mountains and Valleys and God to create an aesthetic of harmony (Molesky-Poz, 2006). Thus, through offering prayer, *copal* incense, liquor, candles, chocolate, sugar, eggs, honey or various flowers, the local *aj iloneleb'* honour the vital forces of the earth, the sacred Mountains and the Valleys and engender a process of attunement.

Before moving on, it is important to note that there are a host of personalistic spirits within Maya cosmovision generally, or the Q'eqchi' *aj iloneleb'* visions of the world particularly, in addition to *Qaawa'* and the spirits of the Mountains and Valleys. Francisco illustrated and summarized the connections between and roles among the various spirits during a detailed interview. "You see there are lots of spirits in healing," Francisco began,

God has existed before the earth was created. God's power is in everything. Whenever we ask God's name he is there. There are other Saints and Apostles that we ask for. They are the ones that are new, they followed Christ and did miracles. That's why God is in everything; he is the wind, air, dirt, sun, plants, water and everything else. These spirits are the four corners of the earth. They are the cardinal points. They are the ones that see us. Today the sun's spirit is with us; tonight the night spirit is with us.

Thomas interrupted his father's description by asking whether the spirits mentioned by Francisco are spirits of people that have since passed on. "The healers that used to heal before are dead but they still exist in the air," Francisco clarified before going further,

Let's say if I die and the next ten years they call my name upon a sick person; the people know I am a healer so they'll ask for my assistance. Although they've died, the spirit of the healer still exists and in healing and in life they can help you. To receive help, we have to do something, and you'll have to give them offerings like cigarettes, *copal*, or

some liquor because you're working and asking them for help and what you want. They will answer you quickly. We call on the Mountain's and Valley's spirits because it's on them that the plants and animals are living. We also call upon those who have died like those who were healers or the Apostles of Christ who also did miracles in healing.

The locally informed notion of relationality or "relational complementariness" that saturates the contemporary cosmovision of the Belizean *aj iloneleb'* involves the core dialogue among *Qaawa'* and the spirits of the Mountains and the Valleys as well as a host of other spirits, ancestors, Christian saints and Apostles. All of these continually guide and assist with their healing work.

Francisco and the other Q'eqchi' healers make no ontological distinction between the "older" Maya spirits and the "newer" Christian spirits. As others have observed (e.g., Thompson, 1930; Maurer, 1997; Kahn, 2006), elements of English Protestantism and Spanish Catholicism have, over many centuries of contact and interaction, fused with Q'eqchi' Maya cosmovision. Contemporary views of reality and approved styles of life, therefore, emulate a syncretic balance. Indeed, Manuel Choc suggested,

God's Mountains and Valleys help us with their power so that the patient gets better. The Apostles also did healing when Jesus walked on the earth, they help also. Jesus was the one that told his apostles to do healing as well. That's why we call on them also.

And later Lorenzo Choc said, "In our work Jesus and the saints and Apostles, John and Peter, they help our work. In our prayers we also call upon the Mountains and the Valleys for permission to do our things." Finally, Manuel Baki noted, "It's important to pray because that was what Jesus left us to do. That's what we do when we hold the pulse [in diagnosing illness], we ask God's Mountains and Valleys to watch over the patient and to leave it in His hands."

Taken together, Francisco, his brother Emilio and the other members of the QHA, embody a worldview and ethos that, to a great extent, centers on a complex network of “social” relationships among themselves, God, and the “older” and “newer” spirits. The point to stress here is that this vision of the world is densely populated. These perspectives of Q’eqchi’ cosmovision are saturated by a host of “personalistic” spirits that are in relation with the *aj iloneleb’* (Halowell, 1960). The relationships to the spirits of the Mountains and Valleys, local sacred ecology and *Qaawa’*, illustrate how *aj iloneleb’* worldview and ethos are sharply oriented toward the cosmos or spiritual worlds—their cosmovision. As manifest through narrative memory, through the knowledge they share with others and the ways of life that conform to that knowledge, the cosmovision of the Q’eqchi’ healers identifies fact with value, gives to “what is otherwise merely actual, a comprehensive normative import” (Geertz, 1973, p. 127).

The Moral Economy of Permission

To build on Geertz’s descriptions of worldview and ethos and to develop our language for expressing and understanding contemporary Q’eqchi’ cosmovision, research and theory in the cognitive sciences and psychological anthropology are explored. Within this literature, the constructs of “schemas” or “conceptual frameworks” are utilized in order to make sense of and understand how individuals and communities view and act within the world around them (D’Andrade, 1992; 1995; Garro, 1990; 1994; 2000; Strauss & Quinn, 1997). As in Cassirer’s (1955) observation that our “apparently given” vision of reality is conditioned and determined by some primary “meaning-giving function” (p. 94), cognitive anthropologists Strauss and Quinn (1997) argued that, to a great extent, “information processing is mediated by learned or innate mental structures that organize related pieces of our knowledge” (p. 49). These “mental structures,” or “schemas” these authors noted, are constructed in negotiation with the

surrounding localized cultural milieu (i.e., ecology, history, values, or language) and become “networks of strongly connected cognitive elements that represent generic concepts stored in memory” (p. 6). In this way, schemas are understood as interpretive processes that mediate one’s vision of the world by providing guidelines or conceptual frameworks central to perceiving, organizing, remembering, representing, making inferences about, narrating, and acting in the world (Casson, 1983; Garro, 2000; Hollan, 2000; Neisser, 1976).

The notion of relationality, around which revolve contemporary understandings of Q’eqchi’ cosmovision, is a locally informed cultural schema or a vision of the world offering a form of practice and perception that “reveals itself through a deeply imagined social consensus” that has been “naturalized” and “formulated by an active history” (Kahn, 2006, p. 66). For the Q’eqchi’ healers in this research, schemas of relationality are firmly rooted in a moral rhetoric. They contain guidelines for “appropriate” or “proper” interactions among members of their community, their local ecology, the spirits of the Mountains and the Valleys, a host of other spirits and Saints, and *Qaawa’* the Creator. Relationships imply morality. Thus, the “language of relationship” (Cajete, 2000, p. 178) expressed by the *aj iloneleb’* is deeply moral.

During ethnographic work with Q’eqchi’ communities in southern Belize, our research team has come to view morality as a historicized set of relational categories that socially bind groups of “people” together, embodied in distinctive symbolic forms and modes of human activity. In addition to human beings, “people” from this view encompasses a host of other-than-human beings that colour the landscapes of Q’eqchi’ cosmovision (Hallowel, 1960; Molesky-Poz, 2006). Far from a solely “mentalistic” notion, abstracted from “embodied knowledge,” visceral affect, and social or historical forces, morality in this context implies tacit ways of being-in-the-world (Csordas, 1990; Good, 1994, p. 51). It is an action-in-place, active adherence

to a “socialized and moralized imaginary” (Kahn, 2006, p. 67). In this way, embodied moral schemas are understood to be built up over time and are in dialogue with other social and political systems, ideologies or ways of life. As Kahn (2006) observed during her work with Q’eqchi’ communities in Livingston, Guatemala, “Religious ideas about reciprocity, nature, and exchange with deities/outside, and economic interchanges that involve paying respect to landowners and tribute to institutions, have merged into a field of morality with a broad scope” (p. 66). These ideas of “reciprocity,” “exchange” or “economic interchanges” regarding payments and offerings required to maintain or establish “proper” or “appropriate” relations, pervade *aj iloneleb’* schemas of morality while shaping contemporary notions of relationality or an embodied sense of “relational complementarity” (Molesky-Poz, 2006, p. 44). To be in “proper” or “appropriate” relationship is to make payments, to offer.

Historically, the earliest Maya glyphs recognized were those for offerings such as fish, iguana, a turkey head, the bound haunch of a deer, ducks and various forms of vegetation. These were all pictorially recognized as payments or exchanges between humans and the other-than-human realm (Thompson, 1972; Molesky-Poz, 2006). Indeed, burial remains at the ancient city of Tikal, stone carvings at Xunantunich and Chich’en Itza, lintels of Cahal Pech, and stela at Nim Li Punit and Lubaantun, commonly depict various forms of ceremonial offerings. As Thompson (1972) argued, “essentially, Maya religion is a matter of a contract between man and his gods. The gods help man in his work and provide him with his food; in return they expect payment” (p. 170).

As observed previously with Emilio and Francisco, *mayejak* (i.e., the making of offerings, or “feeding the fire” in contemporary ritual practice) continues to be a foundational moral and aesthetic activity engendered through Q’eqchi’ cosmovision. “We ask on the valleys and

Mountains to help and offer a payment,” Emilio described, “The incense is used for payment.” In another interview regarding whether or not there are ways in which people can protect themselves against illness, Manuel Choc suggested that “You’ll have to ask for permission so that you won’t get a sickness. It’s like paying a certain fee, but it’s not with money. It’s with incense and candles offered to the spirits.” Similarly, when asked about certain prayers that help with healing, Francisco explained,

Yes there is a prayer said at a certain time. It is said to the spirit of the sickness saying that they’ve done enough to the ill person. Through ceremony, the spirit of the illness is transferred to the sacrifices we make. It’s like an *Alcalde* [community leader], if you’ve done something wrong they will charge you and that money is to pay for the crimes that were committed. It is like paying a certain fee so the sickness comes out of the person.

It’s called *toj* [Payment].

Exchanges between *aj iloneleb’* and the spirits of the Mountains and the Valleys, which resemble a kind of economic tribute, embody the essential cultural logics or interpretive schemas that underlie Q’eqchi’ notions of morality. Morality, according to Kahn (2006), “must be understood as a process of doing. It is an action-in-place, active adherence to a socialized and moralized imaginary” (p. 67). In this way, the *toj*, (i.e., “payment” or “offering”) becomes situated “action-in-place” by which moral relations between humans, their environment, and spirits are sanctioned and maintained. When individuals do something wrong, as in Francisco’s analogy of transgressions against an *Alcalde* or community leader, *toj* is required to mend the moral infringements.

As noted earlier, making ceremonial offerings understood to foster the relations between humans and a spiritual realm is likened to an attunement process, an aesthetic of balance and

harmony. As Geertz (1973) noted, however, this notion that ceremony “tunes” human actions to an envisaged cosmic order is hardly novel. What is required, Geertz suggested, is an appreciation of locally grounded cultural schemas that enable us to provide an analytic account of this process and describe how it functions as a “formative process” or “interpretive activity” in other human activities (Cassirer, 1950). By examining more deeply the Q’eqchi’ idiom of “permission,” this interpretive schema is further revealed.

Throughout various interviews and conversations with the members of the Q’eqchi’ Healers Association, the illustrative notion of “permission,” or the Spanish word “permis,” surfaced repeatedly. This is a concept expressing the moral fabric stitched together by local notions of relationality on the one hand, and economic “payment” or tribute on the other. “Let’s say with fishing or hunting,” Manuel Choc outlined, “we ask for permission to the valleys and mountains. The river is being created by God and we can find some food there. When we don’t ask for permission, bad things can happen like falling into the river or getting some sickness.” “It’s the same with hunting,” Manuel Choc later described,

If you don’t ask permission, you might fall down and hurt yourself or cut yourself or get an illness. It’s like if you have some poultry, like chicken or turkey. If I go and get one without asking, a neighbour might get upset. It’s the same with the valleys and mountains, if you ask permission you can go freely.

Manuel Choc further explained that in asking for permission you first address *Qaawa*’ the Creator, and then the other spirits: “It’s like a father who has a lot of things,” Manuel suggested, “He [*Qaawa*] gave it to them so they look after them. The Valleys and Mountains are there over us and if you don’t ask permission it’s like you’re thieving from them.” Manuel continued,

The spirits are given power by God. They wanted to be in the light and that's why they are given power to feed and take care of animals. They become aggressive at times because they have power over us and that's why we need to ask permission. Let's say a rich person that has huge amount of cattle living in an area tells you to take care of them. If a person later enters into that field you have all the right to speak to that person in a good way if it's the first time. If this is happening often, the rich person might authorize you to shoot the person. It's the same thing with the Valleys and Mountains. If you're not asking permission, it's like they have to ask an animal to attack you. If you enter into the forest without permission, the spirits can get angry and decide what to do. Once you ask for permission, you're free to go anywhere. It's like paying some fees, but only in ceremony. In ceremony you ask for permission.

Within ancient Maya mythology and contemporary Q'eqchi' cosmovision, humans are not "owners" of the earth and its resources. Rather, they are "nurturers," the children of their Creator, their spirits and their ecology (Molesky-Poz, 2006; Tedlock, 1996). When fishing or hunting, when walking through the valley forests or swimming in the mountain rivers, or climbing in a limestone cave, humans are obliged to seek permission from *Qaawa'* and the spirits of the Mountains and Valleys who are the owners of the earth and its resources. Manuel Choc's metaphors of the landowner and a trespasser convey this sentiment. When a permit is not properly obtained, the "owner" (the spirits of the Mountains and Valleys) will "get angry" and can reprimand the moral infraction through snakes, other animals, and through illness.

The notion of "permission" invoked throughout *aj iloneleb'* discourse is moral and legalistic. Permission is bestowed through "proper" payments, offerings or ceremonial performances of "feeding the fire," through a moralized action-in-place (Kahn, 2006). Like a

license granted by those in authority, permission affords opportunity, allows movement, and facilitates rightful action. In the above dialogue with Manuel Choc, “permission” is a moral gatekeeper. To obtain it is to be protected from harm, to invite safety, to “go freely.” To refrain from permission is to transgress, to run the risk of injury or go where “things happen.” Building on this theme, Lorenzo Choc explained that, “If you burn incense or *copal* to the Mountain and Valleys and ask permission, I don’t think you will easily get sick, because you’re free.” “It’s like a person in power,” Lorenzo went on, “you’ll tell him you’ll be going somewhere. That’s the same thing with Valleys and Mountains. Once you ask for permission you’re free. Even if there are thick bushes or thorns, harm cannot happen to you because those spirits know that you are there.” When asked if there are certain ways in which people should “properly” obtain permission from the spirits of the Mountains and Valleys, Lorenzo Choc again suggested,

When you’re hunting, you’ll have to take some incense and when you’re in the middle of the jungle you let it burn and say prayers. It’s like us too. When somebody comes to your home and asks you to sell him a chicken, although he could have seen it, but you won’t give him one. It’s the same way with the Valleys and Mountains. At times they don’t give us game meat. Maybe you’re used to going hunting and when you don’t find anything you’ll get angry and say all kinds of stuff. Maybe the spirits get tired of you and let a snake come in your path because you didn’t ask for permission when you went there. When someone goes out in the forest, and that person communicates or prays to God or burns his incense in the evening and in the morning, he goes and ask permission from God and the Valleys and Mountains. The person asks to get what they want and not the snakes. Although we don’t see God or the other spirits, they know you.

The notions of “permission” and “payment” reveals a Q’eqchi’ theory of morality linked to notions of misfortune, agency, responsibility, protection and risk. Properly obtaining permission through payment or *toj* is a protection against a host of potential problems or “risks” that may negatively impact an individual while in the wilderness. In these perspectives of Q’eqchi’ cosmovision, one is certain that the transgressions of obligations will catch up with an individual sooner or later unless that person does something to reverse the situation. When someone has done something wrong, or failed to properly ask for permission, he runs the risk of being “scolded” by or getting a “lashing” from the spirits of the Mountains and the Valleys. The Q’eqchi’ idiom of permission expresses the moral obligations of “social,” or perhaps more aptly “cosmological” responsibility; it is a principle of personalistic reciprocity. In many ways, permission is the arbiter of morality. Morality, as the cultivation of rightful, responsible conduct, of purposeful action-in-place (Kahn, 2006), is the sure route to protection and prevention of illness and other misfortune or suffering. In this way, morality is not simply following rules.

The Q’eqchi’ *aj iloneleb*’ often reinforce the notion that personal responsibility and individual moralized behaviour is the surest route to the maintenance of community health. Further, the wise investment of “proper” actions that benefit oneself or others in the long run underlies a generalized Q’eqchi’ concept of health and well-being (Harvey, 2006; Watanabe, 1992). The fundamental presupposition of Q’eqchi’ cosmovision, then, is that traditional moral codes expressed through idioms of “permission” or performative actions of making a “payment” are part of the natural order of an interconnected picture of the universe and are established for the purpose of enhancing the health and well-being of individuals and communities. Morality is thus imbued with ontological and epistemological characteristics insofar as the explanation of

generalized events or notions of misfortune in the everyday world are grounded in what could be called a “moral causal ontology” (Shweder, 2003).

Shweder (2003) delineated seven “types” of causal ontologies regarding responsibility, agency and the understood order of reality during a particular illness condition invoked by a wide array of cultures around the world. A “moral causal ontology” refers to transgressions of obligation, omissions of duty, trespasses of boundaries or any kind of ethical failure. Such moral ontologies support the notion that suffering is the result of one’s own actions or intentions and that loss of moral fibre is a prelude to suffering or misfortune (Shweder, 2003). At the center is the social, psychological or behavioural context of health maintenance which substantiates the kinds of “proper” responsibilities community members are to uphold. Within this matrix the moral contours of Q’eqchi’ cosmovision come to life.

A kind of moral economy of permission is, for the Q’eqchi’ healers, a natural philosophy by which the connections between people and unfortunate events are explained and appropriate responses or preventative measures are prescribed. The theme of “payment” and “permission” forms the background of mental life, a schema and an ideological pivot around which the causation of misfortune in Q’eqchi’ cosmovision revolves. “If we don’t ask permission,” Emilio explained, “they [Mountain and Valley spirits] might fail us and it’s the same thing with God. You can’t just clear land, you have to pray and burn candles. The trees might kill you if you don’t do that.” Invocations of “permission” and “payment” by the Q’eqchi’ healers is, then, an embodied cultural schema for specific events in a complex chain of causation connecting individuals to natural happenings. Those natural misfortunes occur within a moral web of significance they themselves have spun (Geertz, 1973). As they provide a vision or perspective of the world, schemas, whether idiosyncratic or shared, colour the day-to-day experiences of

Q'eqchi' *aj iloneleb'* in a normative vision of ordered reality or a “culturally available narrative framework” where a moral economy of permission abounds (Kahn, 2006; Garro, 2000; 2010; Quinn & Hollan, 1987).

The Concept of *Maatan*

Next to the morally laden notion of relationality, the most striking concept in Q'eqchi' cosmovision is *maatan*. Of the 94 interviews held with the members of the QHA over an eight-month period, 64, in some form or another, made reference to this important concept. A detailed discussion with Francisco is used to first introduce the Q'eqchi' idea of *maatan*.¹⁵

“Everything starts from birth,” Francisco began, “if the person is born on a good day, everything will be very good. That person will have friendly relationships among people and the community.” As Francisco continued, he tells the story of two individuals: one born on a good day and lives a happy rewarding life, and the other, born on a day known for difficulty, and leads a life of struggle and contest. “When one has a good life,” he explained, “there are some that are born that way. It is his birth gift that he was born that way. He would do very little so that he has good life. There are some without that gift when they are born. That person can try his best in his life, but no progress is made in terms of well-being.” “It all depends when the person is born,” Thomas clarified, “whether the destiny is to live happy or healthy, the person will live that way. At times a person's destiny might not be healthy and happy. It does not matter how much he

¹⁵ Although each healer in the QHA has an intuitive notion of *maatan* that is employed within their practice and discourse of medicine to some degree, it is important to note that each draws on the interpretive schema of *maatan* uniquely. Since Emilio is the only member of the QHA serving as a *k'atol mavej* or *k'atol xam* (i.e., spiritual guide), he has a specific role of not only offering petitions and thanksgiving during ceremony, but also illuminating life experiences—especially illness episodes—according to the Maya 260-day sacred calendar. When individuals approach the spiritual guides for assistance, Molesky-Poz (2006) observed, they seek a “cleansing” because “he or she is confused, sick, or entangled in problems. The client is “trying to clear his day” (p. 134). The spiritual guide will then “untangle cords,” Molesky-Poz continued, “to illuminate the meaning of one's day, that is one's destiny, one's capacity and potentials according to the sacred calendar” (p. 134). Thus, for Emilio and Francisco (training to join his brother as a spiritual guide), there is a greater involvement of this concept within their narrative discourse and healing work. For the other healers, *maatan* is often mentioned when explaining the etiological aspects of certain conditions. Yet, references to the specific trait constellations of the 260-day sacred calendar are limited.

tries.” When asked whether a person’s actions can determine the outcome of his life, such as making *milpas* [farms] or having good food, Francisco explained,

Your destiny might come with health but you might not know it. When one has their *maatan*, and does something with it, they would work hard so that he is happy. He would think of his life that he is born with something that he can use to have a good life. He would need to make it work. When one thinks that he has a good *maatan*, he would put it to work, in that way he is making himself happy. On the other hand, when one thinks that he does not really care about his *maatan*, to him it would not benefit him in no way, he would be thinking negatively. He would not put his *maatan* to work. There are some with *maatan* to work on their health. Maybe the person does not have money or house, he would be happy since he has put his *maatan* to work or good use. That is his gift to be happy. There are others who would do something else to ensure that they have good health, they would be thinking of ways to stay healthy or be healthy, they would think and find ways to be happy. It is the same, if he wants to do something for himself or work hard, he would have good health.

The concept of *maatan* translates as a kind of “gift” a person has or his “destiny” that is determined by or comes from the day of birth.¹⁶ Other notable English translations or common idioms used to express this notion include, “the days of the person,” his “luck,” “the star of the person,” his “fate,” his “mission” or his “seed.”

Throughout contemporary perspectives of Q’eqchi’ cosmovision are notions that each person comes into the world with particular talents, traits or capacities according to his day of

¹⁶ In several conversations, Emilio and Francisco linked *maatan* to other related Q’eqchi’ concepts like *nawal*, *pohol*, and *chahimal*, the latter of which applies more specifically to the “star” of the person, or based on “acknowledging our star,” Emilio later explained, a guiding principle and value that assists individuals to realize their purpose or mission in life. These four concepts are all related and together express aspects of a person’s “gift,” or “destiny.” To simplify, the term *maatan* is used throughout.

birth. This “gift” influences and guides his development, setting up, in a sense, parameters within which an individual’s personality, life preferences, aesthetic styles, or ways of being-in-the-world can unfold. One’s *maatan* is one’s specialty, one’s virtue and vice, strengths and limitations. In the above excerpt, however, Francisco explained that the development of one’s *maatan*, or the movement of an individual toward his destiny, takes effort on behalf of the individual—you must, “do something with it,” or “put it to work” Francisco suggested. In this way, *maatan* denotes a kind of latent potential as well as the ability to put that potential to good use. It is like a “tool,” something that an individual can work with and which can help them in their life. An individual may have been born with the “gift” or aptitude to become a healer, for example, but the actualization of that potential will depend on their individual effort and on community or parental support, one’s environment, and the ongoing relationships with *Qaawa’* and the spirits of the Mountains and Valleys.

In a later interview Emilio detailed the specific reasons why the particular day of birth will impact the life-course or destiny of the person:

It changes the life because every day is different, the day that you came on the earth that is what you acquired and that is what you will be carrying, that is the exact day that you will start living when you came out of your mother’s womb. When you were in your mother’s womb then you were not carrying or living any days, it is the mother that was carrying the days for you. The first day that you start carrying your days is that day you were born. You start taking that path, and the *maatan* that comes with it. It is like with an Alcalde [community leader] when they are in power the community gives them their responsibilities that they would start carrying out on a certain day, from that moment that they were given that authority. It is the same way with us. When we are born we assume

the responsibility of our days, nobody else will take that away from you because that is yours. That is your path. That is your life, and there is no changing in that. You cannot want and change it to another day because that is your day. You saw daylight on that day and that is the way how it is.

Emilio explained that each day has a certain power or characteristic that is bestowed upon individuals at their time of birth. Whether individuals in a community will be healthy or sick, successful in business, excellent in agriculture, a natural leader, or a renowned *aj ilonel*, is determined by the day in which they are born as well as their individual level of effort and commitment. The “days” here signify two continuous repeating cycles: the set of twenty powers acting as the months, and the count of thirteen days. Together, the thirteen days of twenty months form the 260-day Maya lunar calendar (*chol q’ij*) in the K’iche language (a Guatemalan Maya language) (Molesky-Poz, 2006).¹⁷ From the twenty powers or month names combined with the count of thirteen days, an individual’s *maatan* is determined. At birth, an individual assumes, like the magistrate being sworn into office, the responsibilities that are tied to that particular day. The individual starts “carrying the days” when he is born, an idiom expressive of his new responsibility. “There are twenty months that look like this,” Emilio explained, “*B’atz’, Eh, Aj, Ix, Tz’ikin, Ajmak, Noj, Tijax, Kawok, Ajpu’, Imox, Iiq, Aqab’al, K’at, K’an, Keme, Kej, Q’anil, Toj, Tz’i’.*” Emilio continued,

¹⁷ The 260-day lunar system, sometimes referred to as the *tzolk’in* (Tedlock, 1982), is combined with the *macewal q’ij* organized in eighteen months of twenty days (360 days), with a five-day celebration and gift-giving period called *uayeb* in K’iche’. Together the 365 day cycle combined with the 260 day lunar system provide a fifty-two-year cycle called the calendar round. These calendars are still in use today among many Maya communities, especially the 260-day *tzolk’in* or *chol q’ij* as is seen in this current research. As Tedlock (1982) and Molesky-Poz (2006) observed, the 260-day lunar calendar forms the basis of much Maya religious and ceremonial practice; it is a system of astrology as well as divination. The day signs of the 260-day calendar comprise the essential myths and archetypes of Maya history and narrative as portrayed in the four remaining pre-Columbian Maya books: the Dresden, Madrid, Paris, and Grolier codices (Thompson, 1972). In Appendix A are Emilio’s descriptions of the 20-day names for reference. See also Tedlock (1982), Molesky-Poz (2006), Rice (2007) or Leon-Portilla (1988) for more details regarding the Maya calendar system.

Maybe you were born on a *B'atz'* or *Tijax*. Then your *maatan* is what you are gifted with. Maybe *Aj*, or *Noj* if it is that then that is your *maatan*. If it is that then you are someone who can give advice, a teacher. If you were born on *Keme*, then with that day nobody can just tell you anything because you will stand up and fight and if someone tells you something you are not happy. The same thing with someone born on the day *Tz'i'*. If you tell them anything they are easy to get angry and so as we say it is their *maatan*. If someone born on the day *Q'anil* then he has a good *maatan* for farming he is able to produce corn, beans and will be able to have animals. Someone who is born on the day *Kej* they do not get sick and the same with those born on *Noj*, they are knowledgeable. When someone is born on the day *Aj* then they are very delicate and not strong because it is like a cornfield, the *Aj* are not so strong and happy. That is the way it is. Someone who is born on that day is easy to get sick. Then what we do is we look for ways to help those persons who are so delicate and get sick easily, we would look for their *maatan* and see how we help them. The *maatan* is what they will be doing in their lives that are there since the day that they were born. If someone is able to make money that is their *maatan*. If someone is a teacher, that is their *maatan*. If someone acquires something in their life, that is their *maatan*.

Emilio briefly paused, and then continued his explanation.

Now when we say that twenty months will go in one year then that is saying that the thirteen days and the twenty months would reach to 260 days. When we are seeing the *maatan*, it is thirteen strengths that determines the power of their *maatan*. Each month falling on a different number of days has a different strength. Like let's say today is two *Tz'i'*, then it is balanced. If I was born on nine then I am like missing, I am not balanced

and that is the negative then. I was born on eight it is balanced. If it is 11 then one would be missing again. If I was born on thirteen *Tz'i'* then I would be a great advisor, like a lawyer, and no one can do negative things to me. I am very powerful because I didn't leave any of my *maatan* behind, I brought every single thirteen of them with me.¹⁸

The concept of *maatan* signifies a force or gift that human beings “carry” with them from the time they are born, whether they practise it or not. One's *maatan* is self-evident or empirically observable in their tone, character or quality of life. Each day of the Maya calendar represents a “bundle of meaning” (Molesky-Poz, 2006) or a constellation of traits that are “gifted” to an individual at birth, shaping his personality and destiny.

“It's like a seed,” Emilio exclaimed, “It's like a certain seed, it grows and it would unfold like your life when you were born you take that seed and then that's what different tree you will become in life.” “Yes it is like that.” Emilio continued,

Let's say if a baby is born today on a Thursday in September and on the Maya Calendar it would be two *Tz'i'*. This is what they baby will be carrying and living this life. With the *Tz'i'*, sometimes they don't really do good and sometimes they don't listen and there are times when you just cannot tell them anything and they are aggressive. That is the *maatan* of the day. That is what today is carrying. Like I said every day is different.

Yesterday was a different day and tomorrow will be a different day and so that is exactly what you will be carrying in your life. Yes that is exactly like a seed and you will grow into that certain tree because a seed cannot change what kind of tree to become. So whatever you cannot do, no matter how hard you try, then it is just not for you. Whatever

¹⁸ Here Emilio is describing how each of the thirteen days can moderate the degree to which one's the powers from the 20 months are expressed. Each day within the month has different qualities that change or alter how one's *maatan* manifests.

you cannot do is not for you so you must not be jealous of others. It is just the day that a person born that will determine the life that they will live.

Like the information stored within the seed that becomes a particular kind of tree or plant, so too the constellation of traits or “bundle of meaning” within each particular day guides the development and growth of the individual. The number of days in each month, from one to thirteen, renders the power or particular tone of the day-name or month that is being expressed; it designates the quality of that day and its traits. The twenty different months bestow the general character of the *maatan*, and the days provide its strength or the degree to which it is expressed. If one is born on an even-numbered day then the positive and negative qualities associated with the day are assumed to be in balance. If an individual is born on an uneven-numbered day, there is the risk of excessive virtue or vice: “If it is even then it is balanced and that is positive energies, but when it is odd,” Emilio suggested, “then you carry some negative and positive energies that can be a problem for the individual later in life.” This emulates the “principal of duality” or “relational complementariness” explored previously (Molesky-Poz, 2006).

In many ways, these perspectives of *maatan* can be understood as a Q’eqchi’ theory of personality. It is a cultural schema employed to conceptualize the different “traits” that people in a community reflect grounded in a worldview and ethos where spirituality is the key referent—their cosmovision. According to the DSM-V, personality denotes “enduring patterns of perceiving, relating to, and thinking about the environment and oneself. Personality traits are prominent aspects of personality that are exhibited in relatively consistent ways across time and across situations” (APA, 2013, p. 826). Although there is much debate in the field, psychological theorists generally agree that personality traits are biologically based, are pervasive and inflexible across a broad range of situations, that they differ between individuals, and that they

guide and influence one's behaviour (Goldberg, 1990; Hopwood et al., 2009; McAdams, 2009). Q'eqchi' notions of *maatan* often reflect these perspectives of personality. One's "gift," or "destiny," that is, the "bundle of meaning" impregnated within the 20-day names of the Maya 260-day calendar, are patterns for perceiving and acting in the world. They are stable influences on one's life.

In contemporary psychological research attempts are being made to predict, through various forms of psychometric testing and, to a lesser extent genetics, whether or not an individual's traits will manifest in a pathological or maladaptive fashion at some point throughout his or her life (Browner & Preloran, 2010; Hopwood et al., 2009; Lonnqvist et al., 2009). This is a discourse centred on the future: in effect, a person's "destiny." Knowing how certain psychological traits will impact an individual's development can lead to early therapeutic interventions that may help guide or transform the individual's future. Similarly, knowledge of an individual's *maatan* can, as will be seen in later sections, also lead to "intervention strategies." Moreover, Emilio's analogy of a seed, an innate, predictable pattern within the individual that unfolds throughout life, is reminiscent of the evolutionary determinism that pervades contemporary psychological discourse on individual personality and traits (Crow, 1995; McAdams, 2009; Plomin & Spinath, 2004). In other words, traits and characteristics that are innate patterns or structures within the individual will determine, at least to some extent, their personality and behaviour patterns throughout life.

The Q'eqchi' emphasis placed on the day on which someone is born and the spiritual aura of Q'eqchi' cosmovision points to non-material forces that provide one's "gift" or shapes one's "destiny." In contrast, the discourse in contemporary psychology and the DSM focuses on biological determinants of personality, or personality traits, and are explained by genes, heredity

and occasionally environmental or socio-cultural factors (Plomin, Fulker, Corley, & DeFries, 1997; Rogoff, 2004; Turkheimer et al., 2003). The emphasis here is on material forces shaping one's personality, the "radically materialist thinking" observed by Lock and Scheper-Hughes (1996). In this way, the concept of *maatan* is perhaps closer to Carl Jung's (1957) notion of "archetypes" or Cassirer's (1955) notion of "symbolic forms." These are likened to monistic idealism where a priori mental structures acting as typical patterns impact individual development in a relatively "unconscious" manner.

According to Carl Jung, archetypes are a kind of "supra-individual psyche." They "are not mere objects of the mind but are also autonomous factors" (1969, p. 469); they are "archaic psychic components which have entered the individual psyche without any direct line of tradition" (1963, p. 23). Archetypes are "organs of the pre-rational psyche," "forms" or "categories" of imagination (Jung, 1957, p. 845). Jung (1972) eventually came to define archetypes more clearly as "innate neuropsychic centers possessing the capacity to initiate, control, and mediate the common behavioural characteristics and typical experiences of all human beings irrespective of cultural differences" (p. 45). Jung rejected the view that human beings are a "blank slate or "tabula rasa" upon which experience was inscribed; rather, he held that humans are born with certain predispositions for feeling, perceiving and acting in the world, dispositions based on these ubiquitous archetypes. Similarly for Cassirer (1955), symbolic forms are functional determinants shaping one's thoughts about the world and the way reality appears. They provide a primary "meaning-giving function" to the "making" of our apparently "given" reality (p. 94). Thus, as Pietikainen (1998) argued, "archetypes function as symbolic forms, which direct and structure man's cultural and non-cognitive experiences in a collective "mental infrastructure" (p. 339). This "mental infrastructure" or "innate psychic structure" operates like

an unconscious backdrop colouring perceptions and views of the world and guiding the development of traits, skills, and personality. These notions reflect the Q'eqchi' concept of *maatan* in that the “gifts” individuals receive at birth form categories of imagination acting as a kind of “supra-individual psyche” transcending individual experiences. Even though an analogy for the Q'eqchi' concept of *maatan* may be somewhat elusive, there is a certain ring of authenticity in the comparison here that furthers an understanding of this important Q'eqchi' construct specifically, and cosmovision generally.

The role that personal agency plays in determining one's *maatan* or the life course of the individual, whether he is sick or healthy, rich or poor, varies throughout *aj iloneleb'* discourse. As Manuel Baki outlined, “That is our lives, our luck is our luck. Our *nawal* [*maatan*] is like that. If you do not have much, there is nothing you can do about it.” And as Francisco noted, “When one has a good life...it is his birth gift that he was born that way. He would do very little so that he has good life.” Emilio further suggested, “When we are born we assume the responsibility of our days, nobody else will take that away from you because that is yours, that is your path, that is your life, and there is no changing in that.” In this way, *maatan* is understood to be similar to the notions of personality and the mechanisms of biological heredity underlying it; it is something innate and unchangeable. A view of one's traits or personality that is pervasive and inflexible across a broad range of situations emerges from these excerpts. One's *maatan* is something to be understood to be worked with, not something one should try to move against.

At the same time, however, there are many instances during this ethnographic work when Q'eqchi' *aj iloneleb'* assert that individuals can influence and even alter their *maatan*, can change their preferred styles of life and destiny. “It can change, but it would be hard,” Manuel Choc explained, “you can pray to God and the Mountains and Valleys for your *maatan*, and it

can change, but it is difficult. You can do that in a sacred ceremony. God can help you in that way in terms of health and wealth.” Similarly, Francisco suggested,

It is possible to change that destiny. When a person understands that his destiny is not really good, he will look for a day that it might suit him. It is like he is buying a day for himself that is not meant for him. There are days that the person can borrow. So that he can live happy. In some *maatan*, it brings about sickness. He would ask then that the sickness passes and that new life and well-being be requested so that the person can live a little bit better than the way he was with sickness.

There are contexts and times when individual agency is important and those when it seems irrelevant. With regard to biological or hereditary issues like sex, or situational issues such as where or into what family one was born, there is little room for the notion of agency in *aj iloneleb*’ discourse. Yet, there are times and contexts when agency becomes central and detailed descriptions explain the many ways in which individuals can set their personality traits or life-course in new directions.

Referring to one’s *maatan*, “It can change,” Emilio explained, “you would pray to the Valleys and Mountains, so that if there is suffering targeting you, you would pray to God, you ask for the permission, so that the suffering begins to leave you slowly.” “It is like the government or the Alcalde,” Emilio continued, “When you are beginning to suffer, you would tell him or her to spare you or your life, it is like befriending your destiny. It is in that way that you would not fall ill. Our *maatan* is like that. You can change it, the prayer becomes your help, your assistance, your replacement; you would do something else. It changes in that way.”

Elaborating on this point, Emilio later stated,

It takes time. Like two, three, or four times praying. One is done where our ancestors used to live and work. Praying is done there [referring to ancient Maya temples or archaeological sites]. Another is done at the person's home, it is for the person's permission to live and how he lives. The others are done at the church or ceremony place [referring to sacred caves] with candles. It is done in that way. We would look for a good day and number on the Maya calendar. It can take up to four times praying, as the four cardinal points of the earth. It is possible.

In contrast to his previous sentiments and those of the other *aj iloneleb'*, in this excerpt Emilio suggested that through one's actions, (i.e., prayer to *Qaawa'* and the spirits of the Mountains and Valleys), one's *maatan* can be altered. From this perspective, the prayers offered "become your help, your assistance, your replacement" which can impact the "gift" of the person. In a sense, these become protection against illnesses which individuals would have otherwise been destined to contract. Forming the interpretive core of agency within the concept of *maatan*, then, as observed concerning the Mountains and the Valleys and the moral economy of permission, is what Molesky-Poz (2006, p. 42) described as a "culture of reciprocity." The "destiny" of the person is influenced through "payment" or "feeding the fire" during *mayejak*. Like the ancient Maya who propitiate their Creator in order to bestow well-being and life upon an individual, community, or city (Coe, 1999; Thompson, 1930; 1972), contemporary *aj iloneleb'* and spiritual guides can propitiate *Qaawa'* and the Valleys and Mountains for a good life, a positive destiny, and good health.

Q'eqchi' Metaphysiology: The concept of personhood

Before bringing this chapter to a close, final reflections are offered regarding contemporary Q'eqchi' perspectives of metaphysiology and personhood. Along with the other

sections detailed in this chapter, these notions of personhood play a central role in the interpretive functions of Q'eqchi' cosmovision and the narratives of illness and disorder.

At the *Itzamna* medical garden in southern Belize, several healers in the Q'eqchi' Healers Association, Thomas Caal and our research team engage in a lengthy conversation regarding Q'eqchi' metaphysiology (i.e., the concepts of the mind, heart and spirit, and illnesses known to disrupt their power and proper function). “The brain (*ulul*) works to think,” Manuel Choc began, “this gave us the thought about what we do.” “The role of the brain enables a human to think of activities that needs to be done,” Francisco added. Throughout this conversation and others, the Q'eqchi' *aj iloneleb* describe the brain (*ulul*) to have an important function in initiating and sustaining human action. The work of the brain is frequently referred as *k'a'uxl*, (roughly translated, the thinking that a person does and/or a generalized concept of the mind). According to *aj iloneleb*, the brain is not alone in the thinking process, as the heart is thought to serve an important function. “The brain does the thinking then it goes to the heart (*aam*),” Manuel Baki said. “To me the brain is the same with the heart,” Manuel Choc added, “because our heart is the main organ that makes us living. All the veins come from the heart that goes to the brain.” Francisco suggested that “The heart and the mind are both related. Everything starts in the mind then it goes to the heart. These two organs in the human body go together for a person's thinking (*k'a'uxl*).” “The heart is the main thing that gives us life.” Emilio added “The heart also gives us to think. When we are conceived from birth our heart is the first organ that forms in our mother.” From the perspective of the Q'eqchi' healers, an intimate and important connection exists between the brain of an individual and the heart. Q'eqchi' concepts of mind (*k'a'uxl*), then, refer to the collaborative work carried out by these two important organs. The “mind” and

the “heart” are so interwoven in Q’eqchi’ theories of metaphysiology that any process involving “thinking,” and, therefore, “mental” illness necessarily includes some relation with the heart.

This notion of an important interaction between the “mind” and “heart” of the person in Q’eqchi’ metaphysiology has also been explored in contemporary ethnographic literature. Nigh (2002), for instance, observed how the Maya in Chiapas conceptualize the “heart” as not only the seat of emotions, but also of memory and basic forms of cognition. From this perspective, the heart is an interpretive center for emotional generation and action, guiding thought and behaviour in appropriate directions based on the memory and feelings that arise. Groark (2005) supported Nigh’s notion of a Maya conceptualization of the “heart” as the seat of complex emotions that is part agentive and part interactive, having a powerful impact on one’s thoughts and behaviour. For Groark (2005), the heart is the seat of “deep thinking.” During his ethnographic work with Q’eqchi’ Maya in Guatemala, Kockelman (2007) described the “heart” as “being the agent of actions, the experience of events, the undergoer of changes in state” (p. 353). In addition, the Maya book of creation, the *Popul Vuh*, also suggested that humans were created to have both hearts and minds as separate instruments to connect humans among themselves and with the gods (Tedlock, 1985). While resisting a ubiquitous “Maya” conceptualization of the “heart” and “mind,” it is insightful to observe a trend in the ethnographic literature and our contemporary perspectives of Maya cosmovision regarding the relation between the heart and the mind. This trend is supported by the current ethnographic work among Q’eqchi’ healers in Belize.¹⁹

¹⁹ Although the characteristics of the heart among Maya communities are attributes typically seen of the rational “mind” in Western thought, there is emerging research from the HeartMath Institute and other research programs outlining the important role of the heart and its function in “higher” forms of human cognition, such as intuition (McCraty, Atkinson, & Bradley, 2004). Such research not only challenges Western assumptions regarding the supremacy of the “mental” (Medina, 2006), but also shows empirical support for the conceptualizations of the heart and mind having a close collaboration among *aj iloneleb*.

The Q'eqchi' healers also possess a sophisticated understanding of the human spirit or soul and its connection to the mind, heart and body. "In the human person, *k'a'uxl* is not related to the spirit (*muhelej*)," Lorenzo Choc explained, "The spirit of a person is in the form of unseen object, it is like the air and somewhat separate." "Our spirit is the same as our breath," Emilio agreed, "it is alive with our body and it is in the form of air." Francisco clarified that "it is like two persons exist, one that is spiritual and the other is the physical person." According to the healers, the human spirit (*mu* or *muhelej*) or the soul (*ch'ool*) are closely related and connected to the body in important ways. "The spirit acts like an invisible image in front of a person, whenever he/she is doing an activity. If the spirit senses danger it tries to convince the body not to go or do anything," Francisco explained, "The spirit oversees what will happen to the body in the future, whether it is health, sickness, or troubles." From this perspective the spirit of a person is like an invisible force that envelopes the person's physical body. "It is like two persons exist," Francisco suggested. In some sense the spirit has its own "mind" and agency, thereby directing the individual to take specific courses of action in the material world. "If the spirit sense danger," Francisco explained, it will warn or "convince" the body that some specific action is required. "The spirit is similar to the body," Francisco continued, "it performs activities as humans do but everything is invisible." It is through one's *muhelej* or spirit that communication with the panoply of spirits in Q'eqchi' cosmovision can occur. The spirit engenders the fluid and flexible qualities of the air, moving between and through the material world, including time. Not surprisingly then, Francisco described how the *muhelej* survives the material world and continues to exist in another form once the body of the person can no longer sustain life: "when a person dies, the spirit doesn't; it continues to exist."

The emotional qualities of individuals are thought to derive from one's *ch'ool* or soul as the general Q'eqchi' term for emotions is *xch'ool*. The Q'eqchi' prefix "x" here translates the noun of the soul into a verb. Thus, emotions are primarily expressions of the heart and soul which are both recognized as an external communication of the internal spirit (the way in which one behaves in the world). The term *ra xch'ool* translates as a person who is unhappy, *ra* being a negative emotional state. The term *sa xch'ool* translates as a person who is happy, *sa* being a positive emotional state.

In contemporary perspectives of Q'eqchi' cosmovision, emotions and mood states are not solely understood to be the property of individuals since the environment that is often personified in various spirits can have a powerful impact on an individual's disposition, mood and emotional state. The Q'eqchi' healers often suggested that a negative mood state of an individual is the result of an evil spirit. In other words, spirits can function as external agents that take over the mood or emotional state of the person.²⁰ They often linger in abandoned places or dark corners. They are overpowering and all-consuming when one is in them, just like someone who has an evil spirit working on them. We are changed and become consumed by the emotions represented.

These ideas also relate to the ways in which the "body" (*cha'al*) and its boundaries are conceptualized amidst various Maya communities of Central America, challenging the assumption that the body is conceptualized in the same way across cultures (Lock & Nguyen, 2010; Ross, 2012). The healing practices of pulse reading, manual manipulation, and prayer represent a form of "empathetic intercorporeality" that implies the ability of bodies to mesh together, and to co-experience sensations (Hinojosa, 2002; Harvey, 2006; Nigh, 2002). When Francisco holds the forehead, wrists and feet of his patients, listening, speaking with and feeling their pulse, it becomes a dialogic communion that blurs the borders between patient and healer.

²⁰ This idea is discussed in more detail in Chapter Five.

Similarly, Harvey (2006) argued for a flexible notion of the body, suggesting that “the would-be boundedness imposed by the terrestrial bodies” of humans “may ... be defied and even transgressed” among the Maya, in contrast to the “Western perception of a corporeal factuality, which posits the body as something relatively impermeable” (p. 909). Harvey (2006) pushed beyond the a priori Western conditions of the possible that inform conceptions of self (ipseity) and other (alterity). Among the Zinacanteco Maya of southwest Chiapas, Mexico, Fabrega and Silver (1973) also observed how the “body” is understood as spread out across larger interpersonal and environmental contexts. There is no sense that the individual body at birth is understood as a unique “brand-new” individual. Rather, each body is seen as a composite that is “borrowed” from others in the social world, that is, each person is a fraction of the total Zinacanteco social milieu (Fabrega & Silver, 1973, Lock & Sheper-Hughes, 1996). As such, the conceptualization of the body, self or personhood does not typically align with the so-called “individualistic” Western concept of an internally housed, autonomous being that is separate from other people and objects. The body for the Zinacanteco—as seen in Harvey’s (2006) study of the *K’iche’* Maya of Guatemala—is “spread out” onto one’s family, social group, or cosmological orientation (Fabrega & Silver, 1973, p. 91).

The Q’eqchi’ *aj iloneleb’* also described how the different elements of the person (i.e., heart, mind, spirit and body) work together, just as the different elements of nature work together to form life. During one descriptive interview, Emilio Kal explained how the elements of nature are mapped on and embodied within the human person:

The way I learn in the Maya calendar and our cosmovision is that in our head there is the sky, moon and stars. The sky is where the cosmos are and that’s where the human brain is; the human thinks in that direction. Down to the feet is always the ground the earth is

on the foot. In our left hand there is the water. The blessed water would be on one hand is what we drink. The blessed air is on the other hand. Our heart is the fire, the center of the person. The fire is the breath, our ceremony or prayers. There's always the fire wanting to learn or think deeply. The organs of a human are close to the heart, keeping them warm. Here Emilio suggested that the human body is an image of the cosmos, a cartogram of the Creator, of *Qaawa'* (Molesky-Poz, 2006). Thus, Q'eqchi' cosmovision is not solely an abstract notion through which reality is interpreted, but an embodied aspect of aesthetic sensibilities. This separateness and connectedness among the body and its various elements (i.e., the mind as the cognitive aspects of calendar development and implementation, and spirit as the use of the calendar to determine appropriate spiritual ceremonies and procedures), reflects a sophisticated relationship between these elements (Molesky-Poz, 2006). In this way, the human body is more than just a vessel for the spirit, heart or mind, but a mapping and reflection of space and time. This notion of the person consisting of several components, like the spirit, heart, mind and body, complicates a simple notion of "mental" illness or disorder. Further, simple dichotomies of holism/dualism observed in contemporary ethnographic literature are called into question.

The idea of "holistic" conceptions of the person emphasized over and above a notion of "dualism" emerges as a central element in discourses on Indigenous healing. This is arguably a reflection of the "romantic" tradition influencing much writing and thinking about Indigenous cultures and epistemologies (Ayora-Diaz, 2000; Nigh, 2002; Watanabe, 1992; Waldram, 2004; Watanabe & Fischer, 2004; Wilson, 2008). This position asserts that seemingly separate elements as body, spirit, heart, and mind, or the cosmos, community or environment, all function together in an integrated whole; together they form the conceptualization of the person. As Eder and Pu (2003) explained, "Maya worldview is a holistic way of thinking according to which each

part is related to the universal whole” (p. 49). “The connection between mind and body is strong,” argued Kunow (2003, p. 64) and “Human existence and the cosmos are interrelated and harmonic,” added Molesky-Poz (2006, p. 35). Maya conceptualizations of the world and humans requiring harmony are particularly prominent in contemporary literature, including notions of mind-body-spirit balance. These are often posited as a critical response to the “Cartesian-Newtonian worldview” characterizing Western thought (Fischer, 2001; Eder & Pu, 2003; Kunow, 2003; Medina, 2006; Waldram, 2004).

Our research team agrees that in Q’eqchi’ cosmovision conceptions of personhood are perhaps more “holistic” than conceptions espoused in Western epistemological frameworks. The current ethnographic work, however, seeks a more nuanced position, avoiding typical holistic/dualistic dichotomies by attempting to uncover how local *aj iloneleb’* conceptualize the person. Although notions of holism, harmony and balance pervade contemporary discussions of Maya worldview, personhood and cosmovision, some authors have broken away from the “mainstream” discourse on “holism” to suggest that elements of dualism can also be found (Groark, 2005; Molesky-Poz, 2006).

As observed in previous sections, a “relational complementariness” or “principle of duality” is important in informing contemporary Maya cosmovision which is a vision of life in which all things are intimately related in reciprocal bonds (Thompson, 1972; Watanabe, 1992). “Maya thought is formed by positive and negative, a complementary duality,” affirmed Molesky-Poz (2006, p. 64). This notion was exemplified by the Q’eqchi’ healers through their ongoing relation to the dualistic spirits of the Mountains and the Valleys. It is also seen during the detailed descriptions of the relation between the spirit and the body, “it is like two persons exist, one that is spiritual and the other is the physical person,” Francisco again suggested.

It is not important that the Q'eqchi' healers espouse a notion of the person that involves the elements of spirit and matter. Rather, their notion of personhood involves a fundamental relationship between these elements. The discourse of relationships implies distinct parts that come to work together in some way. Either/or dichotomies may, therefore, mask the complexity of these relationships by forcing us to examine their essential unity on the one hand or their polarity on the other. Reality, it seems, is more complex and involves aspects of dualism and holism (Medina, 2006).

At the core of these perspectives of Q'eqchi' cosmovision, then, are conceptions of personhood as relationships which are understood to involve distinct components yet work together in a complex manner. "A relational way of being is at the heart of what it means to be Indigenous," Wilson (2008) argued, and "rather than viewing ourselves as being in relationship with other people or things, we *are* the relationships that we hold and are part of" (p. 80, emphasis in original). Wilson (2008) further stated that an Indigenous oriented parallel to Descartes's famous dictum "I think therefore I am" might be "I relate therefore I am," highlighting the relational contours of Indigenous conceptions of personhood (p. 80). Similarly, Molesky-Poz (2006) observed,

In Maya thought, the human is understood not as an individual, but as a relational being, that is, one who cannot be conceived of without multiple relations; with one's family and community, the earth, all created elements, other persons, the living and dead, and *Ajaw* [the Creator]. These relationships evoke and cultivate distinct sensibilities and responsibilities (p. 41).

It may be important to ask, to what extent are the relationships making up the contours of Q'eqchi' personhood centered on the cosmos or spiritual worlds? Further, to what extent are they related to the earth or sacred ecology, other people or material aspects of biology?

In a thought-provoking paper, Kirmayer (2007) outlined four “orientations of personhood” that are observed through cross-cultural research which are related to the different ways the person can be defined. These include the values that characterize a healthy or ideal self, the locus of agency in explanations of events and actions in daily life, the various ways of narrating stories about the self, and associated systems of healing. During research among the Q'eqchi' healers, a blending among what Kirmayer (2007) called the “ecocentric,” “sociocentric” and “cosmocentric” self-construals is observed. Unlike Kirmayer's assertion that these self-construals are separate ways to define the person, the present research observed an idiosyncratic amalgamation of views that related more to context than to an overarching assumption that Q'eqchi' communities are one or the other. More important for our purposes, however, is to advance Kirmayer's (2007) assertion that “the distinctive sense of self we experience as adults is a cultural creation, brought into being through narrative constructions and body practices” (p. 234). The point is that through the “formative processes” or “interpretive activities” engendered by a community's worldview and ethos, distinct “narrative constructions” of the self result (Cassirer, 1955; Kirmayer, 2007, p. 234). Thus, the typically “Western” conception of the person “as a bounded, unique...integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgement, and action ... is a rather peculiar idea within the context of the world's cultures” (Geertz, 1984[1974], p. 126).²¹

²¹ This narrative of the “Western” person, however, is arguably a “culture-bound” position that “conforms to fairly recent conceptions of the relation of the individual to society” (Lock, & Sheper-Hughes, p. 52). From this view, then, in helping a patient discover his “true self” and live up to the “ideal of human agency” (Wegner, 2002), the Western-trained psychiatrist or PNP working in Belize, may in fact, be promoting a cultural construction of

According to Kirmayer, (2007), “sociocentric” conceptions of personhood involve the individual’s core relations to others in his social world, family and national identity. The values of collectivism, interdependence, cooperation, filial piety and familism abound and the locus of agency is usually derived from the group rather than the individual. According to the Q’eqchi’ healers, strong social relationships are important. “To have a healthy mind,” Manuel Choc says, “your daily activities are done happily, eat good, stay with your family peacefully.” Or, as Emilio relates, “To have a healthy mind the person will have healthy habits, life, appearance and lives happily among others.” Lorenzo also suggests that “A healthy mind person has good intentions, like sharing resources with neighbour.” And Manuel Baki adds that “A person with healthy mind, they show love and do not dispute with others.” From these excerpts, it is clear that for the individual to live a “good” life and to have a healthy disposition (i.e., to be a person), he must live respectfully with others in the community and be in social harmony.²²

Kirmayer (2007) suggested that the “ecocentric” self-construal relates the individual to the environment, with core values of harmony exchange and balance. As recalled from previous sections, Q’eqchi’ healers and others in the community often understand themselves to be in constant transaction and exchange with organisms in the environment as well as the sacred mountains and valleys. Valerio Canche Yah (2011), respected elder and president of an association of Maya spiritual guides in Mexico, spoke at the 11th Annual Linguistic and Cultural Encuentro of the Mayan peoples. He stated, “Maya cosmovision seeks balance with all our

personhood that is untenable within the patient’s local social world (Good, 1994; Kirmayer, 2007). Understanding the ways in which Q’eqchi’ individuals may construct a sense of personhood out of their local environment and cosmovision is important to counter the assumption that Western perspectives of the self are ubiquitous and universal.

²² It is interesting to note, however, that although Kirmayer (2007) suggested healing modalities that arise from sociocentric communities typically involve collective ritual or family therapy, this is observed among Q’eqchi’ communities only to a limited extent. This suggests that although sociocentric conceptions are part of the Q’eqchi’ notion of personhood, there are other elements that come to bear on the conception of the person in Q’eqchi’ communities.

relations and interrelationship with our whole environment, with Mother Nature, the cosmos, with plants, animals, our neighbours and other people” (p. 2). In contemporary Maya cosmovision, Yah asserted, “people are a part of nature, and that since its inception and evolution over the years, Mayan culture has undergone a development that is in respectful dialogue with the forces of nature” (p. 2). The *aj iloneleb*’ described their power to heal as arising from a relation with the earth, plants and animal spirits. These relations help them restore the required reciprocity between individuals experiencing illness and the natural world. Thus, as we have seen, the “language of relationships” patterning the contours of personhood among Q’eqchi’ communities involves a sacred intimacy with each place and its animals, plants, and local ecology (Cajete, 2000, p. 178).

There is evidence to suggest that Q’eqchi’ healers and others in the Maya villages of southern Belize also think of the person as linked to a cosmic order, or a “cosmocentric” orientation (Kirmayer, 2007). Indeed, the notion of “cosmovision” suggests that this cosmocentric orientation of personhood is a powerful foundation for Q’eqchi’ *aj iloneleb*’. Cosmocentric notions of personhood encompass nonhumans, including the spirits of the Mountains and Valleys, ancestors, and other saints and deities. As Hallowell (1955) observed, each “spirit” has its own perspectives, motives and agency. The core values here are centered on a balance and harmony with the spirits and a focus on “proper” moral actions that foster “good” relations with the spirit world. As Kirmayer (2007) observed, systems of healing associated with such cosmocentric concepts of the person typically involve divination to understand the problem with the individual’s relationship with the spirits and to determine the appropriate actions to restore the cosmic order. The “moral economy of permission” that abounds among contemporary Q’eqchi’ communities suggests that an individual’s relationship to the spirits often involves

transactions and “payments” during *mayejak* or ceremony, emulating a cosmocentric orientation. “Maybe you don’t pray regularly and then you can easily be targeted for sickness,” Manuel Baki explained to highlight the importance of being in “proper” relation with the spirits of the Mountains and Valleys. “If a person is to have a healthy mind,” Francisco added, “the person needs to make a sacrifice (*toj*) to the spirits asking for a blessing in his/her life.”

Although not mentioned by Kirmayer (2007), it is important for the current purposes to reiterate the importance of an individual’s relationship to time, that is, to the day on which he is born (i.e., *maatan*). Throughout the current research in Belize, the notion that an individual’s relationship with the day on which he or she was born on the 260-day Maya calendar emerged as a core aspect of his or her personhood. According to the Q’eqchi’ healers, the development of one’s personality, approved styles or values of life, or perspectives of personhood or the self, all conform to the spiritual pattern bestowed upon the individual at birth, including predisposition to and experiences of illness. “Our health is the most important thing in our life,” Manuel Choc suggested, “If we have healthy mind that is good, as we mentioned earlier it all depends on the person’s gift (*maatan*) at birth.”

Taken together, the different Q’eqchi’ conceptions of metaphysiology and personhood impact the narrative structure of mental illnesses and disorders in several ways. These conceptions also come to bear on the therapeutic encounter. In light of the foregoing, it is clear that the different elements influencing Q’eqchi’ conceptions of personhood impact the contemporary clinical encounter and, therefore, should be of concern for PNPs and psychiatrists working with Q’eqchi’ patients and communities.

Chapter Conclusions

French sociologist, Emile Durkheim (1964), compared culture for humans to water for fish: culture is largely tacit but highly powerful in shaping numerous aspects of experience and psychological processes. The investigation of contemporary Q'eqchi' cosmovision in this chapter reflects Durkheim's observations. On the one hand, cosmovision can be explained and considered as the healers can describe the specific rationale for offering and making payments to the spirits of the Mountains and Valleys. Their vision of reality, or what Geertz (1973) called "worldview," is a conscious concern with the assumed structures of reality and cultural models that link their reality and provide templates for action. On the other hand, cosmovision is implicit and tacit; it is a historicized way of being in the world that implies a kind of "everyday reasoning" that "reveals itself through a deeply imagined social consensus" which has been "naturalized" and "formulated by an active history" (Kahn, 2006, p. 66). From this perspective, their engagement with reality or "ethos" (Geertz, 1973) is an unconscious and "embodied" aesthetic lifestyle that conforms to and is supported by the assumed structure of the world.

To understand and appreciate the healing practices of Q'eqchi' *aj iloneleb'*, this chapter described four "formative processes" or "interpretive activities" of Q'eqchi' medicine: a relationship to the Mountains and Valleys; a moral economy of permission; the concept of *maatan*; and Q'eqchi' metaphysiology and the concept of personhood (Cassirer, 1955). Each of these aspects of Q'eqchi' cosmovision influences the interpretive structures of Q'eqchi' medical reality and thereby shapes Q'eqchi' conceptions of mental illness and disorder.

Underlying these aspects of Q'eqchi' cosmovision is the notion of *majejak*, or Q'eqchi' ceremony. Q'eqchi' *majejak* has a complementary three-fold function. First, it can be performed in order to strengthen the relations among individuals, their environment, and the other-than-

human-realm (i.e., attunement). Second, ceremony occurs as a moralized *action-in-place* where “payments” are offered and “permission” is granted. Third, Q’eqchi’ *mayejak* is performed in order to alter the life course of an individual, to “buy” or “borrow” days that were not meant for an individual in order to augment agency and thereby change his “gift,” or “destiny.” The interpretive and symbolic contours of Q’eqchi’ healing are evident in these three interrelated functions of *mayejak*.

The focus of this chapter was on “formative practices” and how Q’eqchi’ cosmovision constructs the objects to which healers attend. This chapter questioned how Q’eqchi’ cosmovision formulates a culturally distinctive vision of reality and a “context” within which narrative expressions of mental illness and disorder are understood (Cassirer, 1955; Good, 1994). Narratives reflect cultural norms and localized perspectives of viewing the world. As Garro and Mattingly (2000) suggested, the meaning one attributes to emploted events “reflects expectations and understandings gained through participating in a specific social and moral world” (p. 3). Stories follow cultural organizing principles, structures or patterns (D’Andrade, 1992). As such, it is suggested that Q’eqchi’ cosmovision functions to organize the hearing, telling, and remembering of stories among Q’eqchi’ communities, especially those related to health and illness. From this perspective, Q’eqchi’ cosmovision functions as a “culturally available narrative framework” providing the provisional overarching structure that characterizes the telling and interpreting of stories related to mental illness and disorder (Garro, 2000; 2010; Kleinman, 1988; Mattingly, 2000).

Within a given society or cultural community, individuals may use multiple concepts of the person to think about themselves in different situations (Hollan, 2000). As Kirmayer (2007) noted, “what is distinctive about any culture then are the specific elements brought into play, as

well as the relative value placed on these different modes of self-construal” (p. 246). With regard to Q’eqchi’ conceptions of “mental” illness, the issues and cultural logics discussed in this section must be considered. The Q’eqchi’ healers observe an intimate relation between the mind, heart and spirit of the person, while seeing the body as “spread out” over social relations, the cosmos, and the community. Mental illnesses can therefore reflect disharmony in an individual’s psychosocial adaptation, which is manifested and made known to the self and others through infirmity. From this view, illnesses generally, or personal experiences of pain, sadness, anger or envy, particularly, are rooted in social occurrences. They are connected with individuals through specific interpretations of bodily states. From another view, “mental” illness and disorder can also reflect a disruption of relationships among the earth, sacred ecology or the spirits of the Mountains and Valleys, most often represented by the healers through the idiom of “permission.” In these cases, the spirit of the person is “trapped” by the enigmatic powers of the Mountains and Valleys until the individual makes amends, repairs the broken relationships and placates the spirits. The “mental” aspect of illness, then, pertains to the context of the situation, the “interpretive processes” and “formative activities” of the healers’ cosmovision (Cassirer, 1955). As Good (1994) observed, we have a vital role to “investigate how local medical worlds formulate and respond to illness, comprehend aspects of reality, produce distinctive forms of medical knowledge, and shape a crucial dimension of human experience” (p. 177). The perspectives of Q’eqchi’ metaphysiology and personhood coupled with contemporary conceptions of cosmovision inform local medical worlds and produce distinctive forms of medical knowledge and narratives of “mental” illness and disorder.

CHAPTER III: Narrative Structures of Q'eqchi' Mental Disorders

A few hours before the sun dipped below the horizon, Francisco and I made our way to a family home approximately thirty minutes north-west of the southern center of Punta Gorda. Adding to his khaki pants and white-collared dress shirt, Francisco carried a locally crafted, brightly coloured sack that overflowed with the medicinal plant *ru'ujraq' aj tza* (devil's tongue) collected from the Maya mountains earlier that week. In his right hand, he gripped three one-litre bottles filled with a murky green liquid made from a medicinal plant referred to as *tzuul che'* (trees of the hill). In a previous interview, Francisco explained that the young patient we would visit was suffering from a severe form of mental illness called *sachk ch'ool*, meaning one's soul (*ch'ool*) is lost or confused (*sachk*). In the truck, Francisco and I exchanged few words while he carefully attended to his appearance, combing his hair in the truck mirror and pressing his hands repeatedly over the few wrinkles in his collared shirt and khaki pants. Francisco was noticeably concerned about his physical appearance, a professional ethos common among Q'eqchi' *aj iloneleb'*, but perhaps more so today because the patient's family were of Mestizo rather than Maya ethnicity.²³

Arriving at the humble, Mexican style home, many children were still in their school uniforms playing around the yard, a typical scene post-school hours in Toledo villages. As we approached the door we were warmly welcomed inside by Maria, the young patient's mother. Francisco was quiet when we arrived, assuming a humble posture. We were seated next to each other on one of two couches in the main living room. A video game was paused on the television across from us as the kids enjoyed the lingering hours of sunlight outside. After a short time, the children became interested in our presence, coming around, smiling, saying hello and

²³ Mestizo is a term used in many areas of Spanish-speaking Central and Southern America in reference to a person of combined European and Indigenous (i.e., Amerindian) descent.

exchanging a few words in English. Francisco remained composed, looking down at the linoleum flooring with little expression.

Following a few exchanges, the patient's older brother, who was about twenty years old, came into the room carrying another younger boy in his arms, the patient. Maria followed. The young boy, Paulo, pounded his head repeatedly and produced outbursts of inaudible words as he entered the room. Paulo's older brother remained with us, seated in front of Francisco, gently protecting Paulo's head from his self-inflicted, repetitive blows. Francisco asked Maria to bring a bucket of water. The children casually fluttered through the room, now undisturbed by our presence. Paying no attention to the surrounding distractions, Francisco proceeded to break a small amount of *ru'ujraq' aj tza* leaves from his medicinal sack into the bucket.

"You do those things?" Maria then questioned while holding her son's hands with one arm and gesturing to Francisco with the other. Maria was interested to learn about the research work we were doing with the Q'eqchi' healers. Perhaps unsure about the efficacy of their work herself, she eagerly asked more questions in a broken Spanish-English Creole.

"He heal them for sure?" Maria wondered while gesturing to Francisco.

"You mean different people?" I asked.

Maria nods. "Yes."

"They have been doing their healing work for many years," I responded with enthusiasm.

"You think he [Francisco] can help my son?" Maria asked sternly while Francisco continued breaking up the medicinal leaves.

"I don't know for sure. That's part of the reason why I am here," I explained.

Impatient with my response, she interrupted. "Has he healed someone with mental disability like my son already?"

“I haven’t seen anyone like that,” I said, conscious to keep the spirit of the conversation hopeful and positive while assuring her I have only been in Belize a short time. I then asked Maria how old her son was.

“Fourteen,” she replied.

“Was your son like this all his life or did his condition recently develop?” I probed during the silence between Francisco’s mixing.

Maria said that she first noticed something when the boy was about four or five months old. “I start to notice about his eyes first,” she explained, “they started to roll. Then a couple months after that, I noticed that he can’t sit up. After one year my son could not walk or stand at all. When his eyes started to move.” Maria continued, “The doctor in PG said, ‘oh there’s nothing wrong with your baby.’ That’s what the doctors had to say.” “You see,” Maria went on, “They said nothing wrong with him, when he born, they check the babies and said no, nothing is wrong with him. “Ok,” she said sarcastically, “So I took him home.”

After mixing the *ru’ujraq’ aj tza* medicinal herbs, Francisco moved directly to the right of Paulo, and while placing his hands over Paulo’s head, Francisco uttered his prayers. Because Paulo’s arms moved around and interfered with Francisco’s work, Maria continually tried to steady her son. Yet, she remained intent to continue the conversation.

“About three weeks ago,” she said, “We asked Francisco for assistance.”

“How did you hear of his work?” I questioned.

“Oh, from a friend of my grandmother who sought his help with a problem she had,” Maria explained while Francisco moved directly in front of her son.

Placing his hands now on the boy’s wrists, Francisco continued his prayers with the utmost focus and concentration despite the bustling activity of the home. Paulo became visibly

stilled, stopping the swinging motions of his head and arms and allowing Francisco the space he needed.

Maria again continued the conversation while glancing occasionally at her son. “Because before I was trying my best,” she said, “looking for people who can cure my son, nobody can... So I’m trying him [Francisco] now,” Maria says after a pause and with a somewhat desperate and tired laugh while again gesturing to Francisco, who was still intently praying while holding Paulo’s wrists. Maria then broke off the conversation. Turning her attention to Paulo she steadied his hands and wiped some saliva that escaped from his mouth.

Francisco then poured the green *tzuul che’* medicinal liquid on his hands and ran them over Paulo’s head and down his arms. He then poured some of the liquid directly onto the boy’s head while patting him gently on the chest and back. The excess liquid dripped from Paulo’s hair and pooled onto the linoleum floor around the legs of his plastic chair. With a soaking head, Paulo’s wrists were again held by Francisco while he continued to utter his words of prayer. Paulo moved his head back and forth; Maria steadied him. Satisfied with this stage, Francisco moved to the boy’s feet, holding them while again continuing his prayers. Paulo wiped away the liquid that trickled down his forehead. Two times Francisco made a sweeping motion with his hands over Paulo from his head to his feet while blowing gently over Paulo’s body. Satisfied with this process, Francisco asked Maria to help her son drink the *ru’ujraq’ aj tza* he had mixed in the plastic bucket. For several minutes, Maria struggled trying to get her son to consume the medicinal herbs. Paulo refused. Francisco continued to wait patiently, wiping his head from the sweat caused by the summer heat. Other children and older youth who lived in the home continued to walk in and through the living room scene without any particular interest in the

healing encounter. After Paulo eventually took some medical liquid, Francisco explained in Spanish how often the boy was to drink the remaining medication.

Francisco then asked for a small metal tin. Out of his medical sack he pulled a small, neatly wrapped package of leaves. He opened it with care and placed the contents inside the metal container. Francisco lit the small amount of herbs with a lighter. The smoke immediately filled the air, saturating the senses.

Francisco then proceeded to the left side of the boy. While crouching down with one hand on the boy's chair and the other holding the flaming metal tin, Francisco, ever so softly, uttered more words of prayer. The smoke surrounded Paulo as his head and limbs continued to move jarringly in all directions. Maria patiently continued to steady her son. After a few moments, Francisco moved to the opposite side of the boy, and repeated uttering his prayers while the incense enveloped the room. Francisco again repeated this process from directly behind the boy, and then moved in front of him, while continuing to pray uninterrupted. While still in front of Paulo, Francisco moved his hands gently in and through the smoke and continued with a downward, swooping motion across the boy's head and arms, a motion referred to as the *jilok*, or spiritual massage. Paulo, seemingly unaware of Francisco's presence, continued to bang his head with his own hands.

Leaving the tin of incense to burn on the floor, Francisco moved his hands through the smoke and onto the boy's forehead, as prayers continued. This pattern was repeated for about three minutes while Paulo moved his head around slightly and Maria, still in front of her son, tried to help Francisco do his work. Francisco moved his hands from the boy's head to his chest and back, one hand in front and one on the back of the boy, directly over his heart. Paulo grunted loudly as Francisco's hands were gently placed on his chest. Francisco held Paulo for several

seconds while again repeating his prayers. Following this, Francisco took the metal can, and walked around the boy in a counter-clockwise circle, blowing and gesturing the smoke to surround him. The mother now stood back, as Paulo curled his limbs onto the chair and continued the rhythmic movements of his head.

“*Bueno*,” Francisco exclaimed (a commonly used Spanish term meaning “good” and which signalled the end of his work). Francisco then took a handful of the *ru’ujraq’ aj tza* herbs from his sack and talked with Maria for nearly ten minutes about the daily preparation of medication for her son. At the end of their brief discussion Maria seemed to understand the necessary steps. We said farewell to Paulo and the other children who remained scattered about the house and yard.

Q’eqchi’ Conceptions of “Mental” Disorder

Francisco and the other members of the Q’eqchi’ Healers Association have a sophisticated taxonomy of illnesses known to affect the mind of an individual. This is a collection of locally situated disorders that are “made” or “mediated” by the symbolic forms and interpretive practices of their cosmovision, empirical observations, and traditional knowledge. As demonstrated in Chapter Two, the aesthetic styles of life (i.e., ethos) and the assumed structures of reality (i.e., worldview) can generate distinctive modes of experience, which can inform an array of culturally distinctive forms of personhood and illness conceptualization (Good, 1994; Kirmayer, 2007). From this view, medical reality is not that which precedes interpretation, rather it is “that which resides amidst the interactions or relationships among the physical body, the lived body, and the interpretive activities of the sufferer, healers, and others in the social world” (Good, 1994, p. 176). Medical knowledge, Good (1994) further argued, “is knowledge of distinctive aspects of reality mediated by symbolic forms and interpretive

practices” (p. 176). Thus, the contemporary nosological perspectives of the Q’eqchi’ *aj iloneleb’* in this study, like those of Western psychiatry, have, through various interpretive practices, symbolic forms and historical processes, come to comprise a relatively stable core of illnesses known to impact the mind of an individual. The focus of this chapter is to understand and interpret Q’eqchi’ nosological systems of “mental” illness involving the factors—spiritual, cultural, social, historical, cosmological or otherwise—implicated in their articulation, narration, and construction. How does Francisco understand Paulo’s condition in the opening ethnographic sections of this chapter? Are there Q’eqchi’ theories of mental illness or disorder that Francisco and the other healers in the QHA draw on to interpret illness experiences? What are the nosological systems at work within Q’eqchi’ healing contexts? Finally, how are identified categories of mental illness recognized by the Q’eqchi’ healers related to or influenced by “mainstream” diagnostic systems developed by American psychiatry and employed by the Belize Ministry of Health?

The 94 qualitative interviews held with the six practicing members of the Q’eqchi’ Healers Association over nine months began by understanding, unpacking and classifying the different illness conditions known to impact the mind of a person (Rothe, 2000). This work built on previous research conducted by James Waldram and the Ottawa botanist research team (Bourbonnais-Spear et al., 2005). Within the interviews conducted for this research, there were primarily four identifying factors used to classify and distinguish among different mental illness conditions: etiology; symptomology; demographic population; and therapeutic approach.²⁴ What arose from the data were 17 related yet distinct stories of illnesses known to negatively impact

²⁴ Other identifying factors (i.e., temperature, description of blood, or severity (i.e., prognosis) also arose within the transcripts but were less significant for the members of the QHA in terms of making distinctions among different mental disorders. Prognosis did, however, come to bear on the different degrees of conditions within the Childhood / neurological narrative genres as discussed later and also seemed to be more relevant in distinguishing between the different “narrative” genres as opposed to the 17 specific mental illness and disorders.

the “mind” of a person in some way. All of the 17 conditions discussed throughout this work can be classified under the broad Q’eqchi’ rubric of “mental” illness insofar as they deal directly with the mind, heart, soul or spirit of the person, narratively engender a set of mood conditions (i.e., anger, fear, sadness, jealousy, or worry, etc.), and can be distinguished from illnesses that “only” impact the body (i.e., malaria, skin and skeletal conditions, diabetes, or various localized pains, etc.).²⁵

As noted in Chapter One, analysis of the 94 interviews began by creating separate analytic files for the 17 mental illnesses and then comparing them among the different healers and the four identifying factors (Rothe, 2000; Smith & Osborn, 2003). Thus, there were three overall analytic categories or units of analysis to consider: different qualitative descriptions among the *aj iloneleb’* for each illness condition (i.e., healers); the 17 “mental” illness conditions; and the four identifying factors used to distinguish between the different conditions (i.e., etiology, symptomology, demographic, and therapeutic approach).

The first stage of analysis detailed a continuum of consensus that ranked each of the 17 conditions based on the frequency of the healers’ descriptions across the four identifying factors. This first stage focused on the healer as the analytic category to explore how the different illnesses were described and recognized. Based on consensus methodology adapted for use with these qualitative data (Ankli, Sticher, & Heinrich, 1999; Treyvaud-Amiguet et al., 2005), the frequency of the mention of a particular cause, symptom, demographic population, or treatment

²⁵ We say “only” impact the body lightly here as what we will come to appreciate regarding seemingly physiological conditions, even those that seem as clearly physiological as *kaxum xul* or snake bite, can invoke a host of mood states and conditions that may be interpretable as “abnormal” by the Q’eqchi’ healers and patients. They require some form of treatment and attention, but more importantly they carry with them powerful moralizing ideologies, idioms of expression, and “culturally available narrative frameworks” almost indistinguishable from those invoked regarding other “mental” illness conditions (Garro, 2010, p. 71). Thus, *kaxum xul* is included in these discussions proving to be an intriguing “mental” illness insofar as it involves a high degree of emotional disturbance and a recognizable relation to the plot forms and narrative structures similar to “mental” illness conditions involving spirit “attack.”

approach among the healers was used to quantify their degree of consensus. This process allowed us to transform the qualitative themes into nominal quantitative categories. An overall consensus score was then given to each of the 17 conditions. Table 1, 2 and 3 illustrate this process for a single condition (i.e., *eet aj yahel*) regarding separate identifying factors. The total scores from Tables 1, 2, and 3 were then added together with the overall demographic score, indicative of the demographic category most or solely vulnerable; in this case, a score of 1.0 (i.e., all healers mentioned the same age category for this condition). The combined consensus score for each of the four identifying factors then became the overall consensus score for *eet aj yahel*. This process was repeated for each of the 17 conditions. Table 4 presents the total consensus scores for all 17 mental illnesses.

A continuum of *aj iloneleb*' consensus was constructed from the qualitative interviews and ethnographic data for two reasons. First, degree of consensus was assessed in order to later collapse the analysis of different mental illnesses and disorders across all *aj iloneleb*' in this study. Second, consensus was employed to examine the extent to which the healers' descriptions of a particular condition varied. Constructing a continuum of consensus was one approach to examine these important nuances in the data.

Table 1: Consensus scores for causal factors of <i>eet aj yajel</i> (falling down by evil spirit OR "epilepsy")						
Cause	Francisco Caal	Manuel Baki	Emilio Kal	Lorenzo Choc	Manuel Choc	Consensus frequency
Spirit "attack"	X	X	X	X	X	1
In the air	X	X		X		0.6
Already in the blood (i.e., heredity or family traits)	X			X		0.4
Thinking too much					X	0.2
Fright					X	0.2
Failure to seek permission	X					0.2
From other conditions (i.e., <i>kaanil</i>)	X				X	0.4
Falling down					X	0.2
						Consensus total: 3.2


Note: This table illustrates the process of developing a consensus score for causal factors (i.e., etiology) of the illness condition *eet aj yahel*. Any mention of a specific cause was recorded as a positive affirmation and is shown in the table by an “X”. The consensus score for each cause was calculated as the number of healers who mentioned, at least once, a specific cause divided by the total number of healers. The total consensus score was achieved by summing the consensus frequency scores for each individual cause.

Table 2: Consensus scores for symptoms of <i>eet aj yajel</i> (falling down by evil spirit OR "epilepsy")						
Symptoms	Francisco Caal	Manuel Baki	Emilio Kal	Lorenzo Choc	Manuel Choc	Consensus frequency
Falling down unconscious	X	X	X	X	X	1
Teeth clenched	X	X	X			0.6
Eyes rolling back		X		X	X	0.6
Neck Twisted	X				X	0.4
Twisting hands and lips	X		X		X	0.6
Black and blue complexion	X		X			0.4
Pale complexion		X				0.2
Trembling					X	0.2
Fever/chills	X					0.2
						Consensus total: 4.2

Note: Using the same method as in Table 1, the frequency of each symptom attributed by a healer was recorded. Any mention of a specific symptom was recorded as a positive affirmation and is shown in the table by an “X”. The consensus score for each symptom of *eet aj yahel* was calculated as the number of healers who mentioned, at least once, a specific cause divided by the total number of healers. The total consensus score was achieved by summing the consensus frequency scores for each individual symptom.

Table 3: Consensus scores for treatment of <i>eet aj yahel</i> (falling down by evil spirit OR "epilepsy")						
Treatment approach	Francisco Caal	Manuel Baki	Emilio Kal	Lorenzo Choc	Manuel Choc	Consensus frequency
Prayer	X	X	X	X	X	1
Medicinal plants	X	X	X	X	X	1
<i>Awax</i>	X	X		X	X	0.8
Other ceremony (i.e., burning candles and other materials)	X		X			0.4
						Consensus Total: 3.2

Note: Using the same method as in Table 1 and 2, the frequency of each treatment method attributed by a healer was recorded. Any mention of a specific treatment method was recorded as a positive affirmation and is shown in the table by an “X”. The consensus score for each treatment method of *eet aj yahel* was calculated as the number of healers who mentioned, at least once, a specific treatment divided by the total number of healers. The total consensus score was achieved by summing the consensus frequency scores for each individual treatment method.

Table 4: Continuum of Q'eqchi' healers' Consensus Scores			
Q'eqchi' name	English name	Consensus score	
<i>Kaanil</i>	Fright or "soul" loss	12.2	High
<i>Eet aj yajel</i>	Falling by evil spirit	11.6	
<i>Rahil ch'ool</i>	Sadness of the soul	10.8	
<i>Wax ru</i>	Extreme "craziness"	10.2	
<i>K'axum xul</i>	Snake bite	10.2	
<i>Awax</i>	Illness of the moon	10	
<i>Rilom tzuul</i>	Mountain spirit illness	9.6	
<i>Waxk'ay</i>	Mild "craziness"	9.4	
<i>Tib'l jolom</i>	Headache	8.6	
<i>Sachk ch'ool</i>	Memory loss	8.2	
<i>Po'ol k'a'uxl</i>	Spoiled mind	8.2	
<i>Oksinb'il kaan</i>	Fright illness	8	
<i>Aj ookil</i>	Insomnia	7.2	Low
<i>Sikirk</i>	Numbness	6.8	
<i>Ch'i' ch'i' il</i>	Stressed	6.6	
<i>Xiw xiw</i>	General anxiety	6.2	
<i>Chiqwual xjolom</i>	Hot head illness	5.8	

Note: Using the same consensus methodology for *eet aj yahel* presented in Tables 1-3, this table displays the consensus values for each of the 17 different mental illness conditions. The overall continuum of consensus ranges from the highest value of 12.2 for *kaanil* to the lowest value of 5.8 for *chiqwual xjolom*. The higher the consensus score depicts the greater consensus among the healers for that particular condition.

The main point here is that not all of the 17 mental illness conditions were equally recognized by *aj iloneleb*’ in the QHA, nor were the narrative descriptions for each condition the same when looking at the healer as the unit of analysis. As mentioned in Chapter One, the medical knowledge of Q’eqchi’ healers can vary extensively. Each is apprenticed under a different master and, based on practical experience and the type of cases observed during their healing service, each adds a particular flavour to his craft. Francisco and Emilio, for example, demonstrate a greater degree of medical experience and knowledge of Q’eqchi’ cosmovision and spirituality as a result of their training as a *k’atol mayej* or *k’atol xam*, as “spiritual guides” (Molesky-Poz, 2006). This knowledge base colours their narrative descriptions of mental illness and disorder with a greater spiritual aura, naturally leading them to attend to and speak about these aspects of an illness more readily compared to the other healers. Although they recognize many of the same mental illness conditions, the other four healers in the QHA are not as experienced in picking up the nuances between and among the different conditions. In presenting these conditions, then, this research team was challenged to highlight the remarkable similarity in some of the healers’ narrative descriptions of mental illness conditions (i.e., conditions with “high” consensus), while also acknowledging some of their discrepancies (i.e., conditions with “low” consensus).

Further, when speaking of broad notions of a Maya medical system, it is important to recall that there are no codified historical or contemporary texts that document the medical knowledge of the Maya people. As explored in later chapters, *aj iloneleb*’ knowledge of “mental” illnesses are, to a great extent, embodied, tacit, visceral and practical, as opposed to semantic, doctrinal, categorical or representational. Q’eqchi’ therapeutic encounters often lack

“talk therapy” or discrete processes of language, yet are rich in performative or enacted dramas.²⁶ Q’eqchi’ diagnostic processes, that is the ways in which *aj iloneleb*’ “know” whether an illness is one condition or another, also involve multiple sources of knowledge: those which are empirical, “traditional,” spiritual, embodied or intuitive. Not all of these forms of knowledge are easily translated to the representation structure of narrative or language (Harvey, 2006; Mattingly, 2000), let alone maintained through translation in this research project.²⁷ Additionally, communicating their categorical systems of mental illnesses and disorders for the purposes of research was foreign to the Q’eqchi’ healers. As demonstrated throughout, there are broad theories of Q’eqchi’ “mental” illness invoked during patient consultations, therapeutic encounters and diagnosis. Although the discussions of Q’eqchi’ mental illnesses and disorders are presented throughout in a format familiar to the Western audience, readers are reminded that even the best descriptions of Q’eqchi’ medical knowledge will elude the subtly intuitive or embodied nature of Q’eqchi’ cultural knowledge and diagnostic activities.

Four Narrative Genres of “Mental” Illness and Disorder

Once a general continuum of consensus was produced by looking among the different healers for each condition, the 17 recognized mental illnesses were then compared to each other on the basis of the four identifying factors. In other words, the second stage of analysis focused on the illness conditions as the primary analytic category while collapsing across the healers.

What emerged when comparing the 17 different conditions were common stories about illnesses that impact the mind of a person, stories with discernible plot structures, casts of characters, themes, genres, recognizable teleology or “directedness,” theodicy, and soteriological

²⁶ These issues of “language” and the relation between embodiment and narrative are taken up more directly in Chapter Five.

²⁷ To minimize usual issues that can arise with translation work, a “double translation technique” was employed throughout all interviews and recorded conversations with the Q’eqchi’ healers. See Chapter One for more details.

elements. The common stories of Q'eqchi' mental illness outlined by *aj iloneleb'* resembled what Kirmayer (2000) referred to as “broken narratives” or what Good (1994) described as “unmaking” processes: the disruptions of a lifeworld or normal rhythms of a person's everyday life and the relationships central to that life. In general, Q'eqchi' stories of mental illnesses and disorders are those of disruption, of disturbance, of the unsettling feeling due to physical limitations of the illness state. What became apparent through these comparisons was an overall narrative structure to the Q'eqchi' healers' conceptions of mental illness and disorder. What developed during this analysis, therefore, was a way of thinking and speaking about Q'eqchi' mental illnesses and disorders in narrative terms.

Narratives are stories that offer a way for people to make sense of and construct a coherent understanding of experience. Through “narrative configuration,” the succession of occurrences in day-to-day life are recounted and ordered into a loose chronological sequence (Bruner, 1986; Hurwitz, 2000; Mattingly, 1994, p. 813). As Mattingly (1994) outlined, “any particular event gains its meaning by its place within this narrative configuration, as a contribution to the plot” (p. 813) and that “it is the plot which makes individual events understandable as part of a coherent whole, one which leads compellingly toward a particular ending” (p. 813). Through narrative, people make sense of how things have come to pass and how their actions and the actions of others have helped shape their history. Narratives “emplot” or “domesticate” experience by rendering it recognizable within a familiar cultural world (Becker, 1997; Mattingly, 1998). In this way, narratives enable a meaningful vision of the present based on a set of cultural relationships with a constituted past and an anticipated future (Ricoeur, 1981). Thus, narratives not only order and recount experiences or events; they also project activities into an imagined future, organizing strategies and desires teleologically,

“directing them toward imagined ends or forms of experience which our lives or particular activities intend to fulfill” (Good, 1994, p. 139).

Regarding various forms of illness experiences, several authors note that illness can disrupt the “normal” day-to-day functioning of an individual, bringing into question his or her imagined endings and the cultural meanings previously derived from routine activities (Becker, 1997; Kirmayer, 2000; Mattingly, 2010). Illness experiences often create an “unmaking of the life world” as Good (1994) observed, moments that stand out or interrupt common everyday experiences. Illness can also bring into question the moral values underlying one’s concept of personhood and challenge one’s culturally laden concept of self (Hatala, Waldram, & Crossley, 2013; Hunt, 2000). Narrative in the contexts of various forms of illness experiences, or what Good (1994) termed “narrativization,” can foster a “re-making of the lifeworld,” not only assisting people to make sense of the potentially troubling and disrupting illness experience, but also helping to re-construct a morally valued and conceptually coherent concept of the self or personhood. In this way, Bruner (2008) argued that narrative is often “about the violations of the shared ordinary, about how such violations are resolved” (p. 36) and about how these “deviations from shared ordinariness” are culturally and morally rendered “both conventional and manageable” (p. 35).

As noted in Chapter One, most narrative research of illness and healing in cultural psychiatry, psychology and medical anthropology has been about patient experiences. Indeed, a wealth of research into the social contours of illness and health has been conducted within a framework often referred to as a “narrative turn” in health-related research (Becker, 1997; Garro & Mattingly, 2000; Garro, 1994; 2010; Hatala, 2011; Kirmayer, 1996, 2000; O’Neill, 1996;

Waldram, 2012). To look at, talk about, and interpret the structure of healing epistemology through a narrative lens, however, is somewhat unique.

Based on the ethnographic research with the members of the Q'eqchi' Healers Association, I argue that narrative is not only a form in which experience is represented, ordered, and recounted, in which events are presented as having a meaningful and coherent order (Bruner, 1986; Mattingly & Garro, 2000), but also a medium through which the epistemological structure of Q'eqchi' medical reality is revealed and understood. In this way, the different mental illnesses and disorders recognized by the *aj iloneleb'* represent competing narrative structures, genres, or plot forms allowing the healers to, as Ricoeur (1981) said, “extract a configuration from a succession” (p. 278).

In Paulo's case described in the opening section, Paulo's family requested assistance from Francisco and in so doing they described the story regarding how or why Paulo's condition may have begun and how he feels as a result. During the healing encounter, Francisco also “communicates” with or “reads” the various “texts” of the illness through his prayers and reading of the pulse, which further help to fill in or explicate the unfolding drama.²⁸ From this succession of unfolding events, from the confluence of Francisco's diagnostic techniques and the patient's or family's story, Francisco begins to “emplot” and configure Paulo's illness experience in the context of already known structures or plot forms of illness narrative.

This is a process articulated by Mattingly (1994) wherein she observed that “Narrative plays a central role in clinical work not only as a retrospective account of past events but as a form healers and patients actively seek to impose upon clinical time” (p. 811). During their work, Mattingly continued, “healers actively struggle to shape therapeutic events into a coherent form organized by a plot. They attempt to emplot clinical encounters by enfolding them into larger

²⁸ These ideas of “reading” patient “texts” used here are developed and expanded in succeeding chapters.

developing narrative structures” (p. 811). In Mattingly’s (1994) excerpts there are three uses of the term “narrative.” The first involves patients’ retrospective accounts of past illness experiences, including imagined ways in which the illness occurred and potential solutions to its predicament. In this regard, a wealth of experiential narrative research has been conducted largely from the patients’ perspective (Becker, 1997; Garro, 1994; Gelech & Desjardins, 2010; Hatala, 2011; Hunt, 2000). The second use of narrative Mattingly described refers to a “form” that patients impose on clinical time. This involves understanding the cultural logics employed during the interpretation of a clinical encounter, which is also richly developed and presented in psychological and medical anthropology literature (Desjarlias, 1992; Good, 1994; Mattingly, 1998; Waldram, 2012). The third narrative process described by Mattingly (1994) involves a form that healers impose on clinical time. This is based on “larger developing narrative structures” within which a particular medical encounter is “enfolded” and brought to life (p. 811). Since a minimal amount of literature has investigated the narrative forms that healers or “medical experts” impose during clinical encounters, this is the focus for the current chapter and frames the overall arguments and conclusions of this research (Good, 1994).

Based on the analysis among the 17 different mental illnesses, four broad narrative structures or genres emerged: (1) Childhood / neurological disorders; (2) “Fright”; (3) “Thinking too much”; and (4) Spirit “attacks.” Each of these narrative structures involves, to some degree, a similar story, an unfolding course of events that could be described as “prototypical plot forms” (Good, 1994) or a general “narrative type” (Frank, 1995).

According to Frank (1995), “a narrative type is the most general storyline that can be recognized underlying the plot and tensions of particular stories” (p. 75). These narrative types are seen as a repertoire of cultural scripts or cognitive tools that provide, however modestly,

models for social action and drama. Similarly, Good (1994, p. 164) argued that “‘an illness’ has a narrative structure,” a structure that involves particular “prototypical plot forms” which give stories coherence and order through which experiences and events are joined together to create meaning in the overall story. Good (1994) described these general illness narratives as “cultural resources” that can be drawn upon during disrupting illness experiences (p. 145).

Moving from the work of Good (1994) and Frank (1995), these broad epistemological structures are referred to here as “narrative genres,” signifying a “common stock of stories” that are part of the Q’eqchi’ healers’ visions of the world. They are interpretive tools to apprehend medical and social reality, enabling them to recognize, create meaning from, and “enact cultural scenarios” with which they are familiar (Good, 1994; Mattingly, 2000, p. 197).

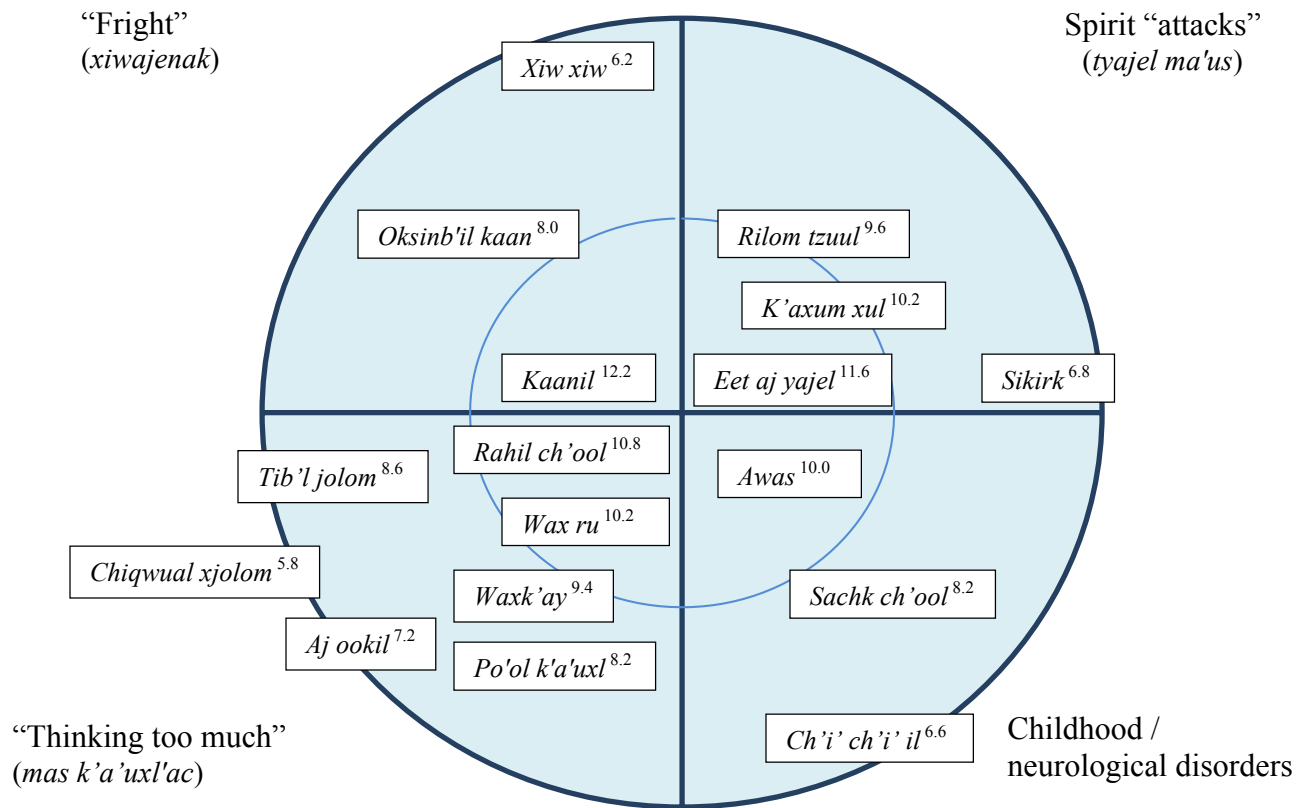
The concept of a “genre” began as an absolute classification system where literary categories (i.e., poetry or prose) and theatrical categories (i.e., comedy or tragedy) had specific and calculated styles related to the theme, form, and content of aesthetic expression (Devitt, 2004). Speech patterns and behaviours in one genre were considered inappropriate in another, unless the intent was such as in a tragic-comedy. As Devitt (2004) noted, genre later became a more dynamic tool to help the public make sense of unpredictable artistic expressions. In this way, genres are understood to be culturally formed by social conventions that change over time as new genres are invented and the use of old ones discontinued. The concept of genre remains useful in artistic disciplines insofar as it provides, however loosely, an initial interpretative framework within which meaning may be produced during an aesthetic encounter.

The four recognizable “narrative genres” function for the Q’eqchi’ healers in a similar way. They provide an initial epistemological framework within which medical reality is meaningfully approached and interpreted. Each of the 17 identifiable “mental” illness conditions

can be grouped together under one of the four broad “narrative genres” on the basis of overarching themes that run through the healer’s descriptions. In many ways, these themes are based on patterns within the four identifying factors of each mental illness or disorder, that is: how the onset of the illness is understood (i.e., etiology); how the temporal unfolding of the illness plays out in the patient’s life (i.e., symptomology and prognosis); the demographic population most afflicted by the condition; and the interpretive logics underlying the therapeutic process. In other words, there are four broad genres of mental illness recognized by the Q’eqchi’ healers, each involving a discernible cast of characters, direction or teleology, ways of dramatization, props, and themes. Figure 1 visually illustrates how each of the 17 “mental” illness conditions spatially relates to the others and the four general “narrative genres.”

Building on the notion of a continuum of consensus presented in Table 4, the center of Figure 1 is used to represent the point at which consensus for the descriptions of each condition are the highest across the different healers, and are, with the exception of *wax ru* and *waxk’ay*, the most “typical” conditions diagnosed by the healers as well as the “prototypical” cases within each narrative genre. *Wax ru* and *waxk’ay* are highly consistent among the healers descriptions, yet they are recognized as serious and rare; they are not the most “typical” conditions diagnosed within the “Thinking too much” narrative type. The conditions spatially mapped on the periphery are those with a lower score of consensus as presented in Table 4. Illness conditions within one “narrative genre” that reflect similarities in another genre are spatially positioned to reflect such a relationship. Thus, these “narrative genres” are presented here as fluid heuristics for understanding the different kinds of Q’eqchi’ mental illnesses and disorders and are not meant to be understood as rigid categories. Rather, these different narrative genres are, to some extent, spectrums that merge and blend into each other.

Figure 1: Four Q'eqchi' "narrative genres" and their 17 associated "mental" disorders



Note: Each of the 17 conditions are displayed here within one of the four broad narrative genres. Some conditions also resembled descriptions close to other narrative genres and are thus located close to a related narrative genre. The value in the superscript of each condition is the total consensus score from Table 4.

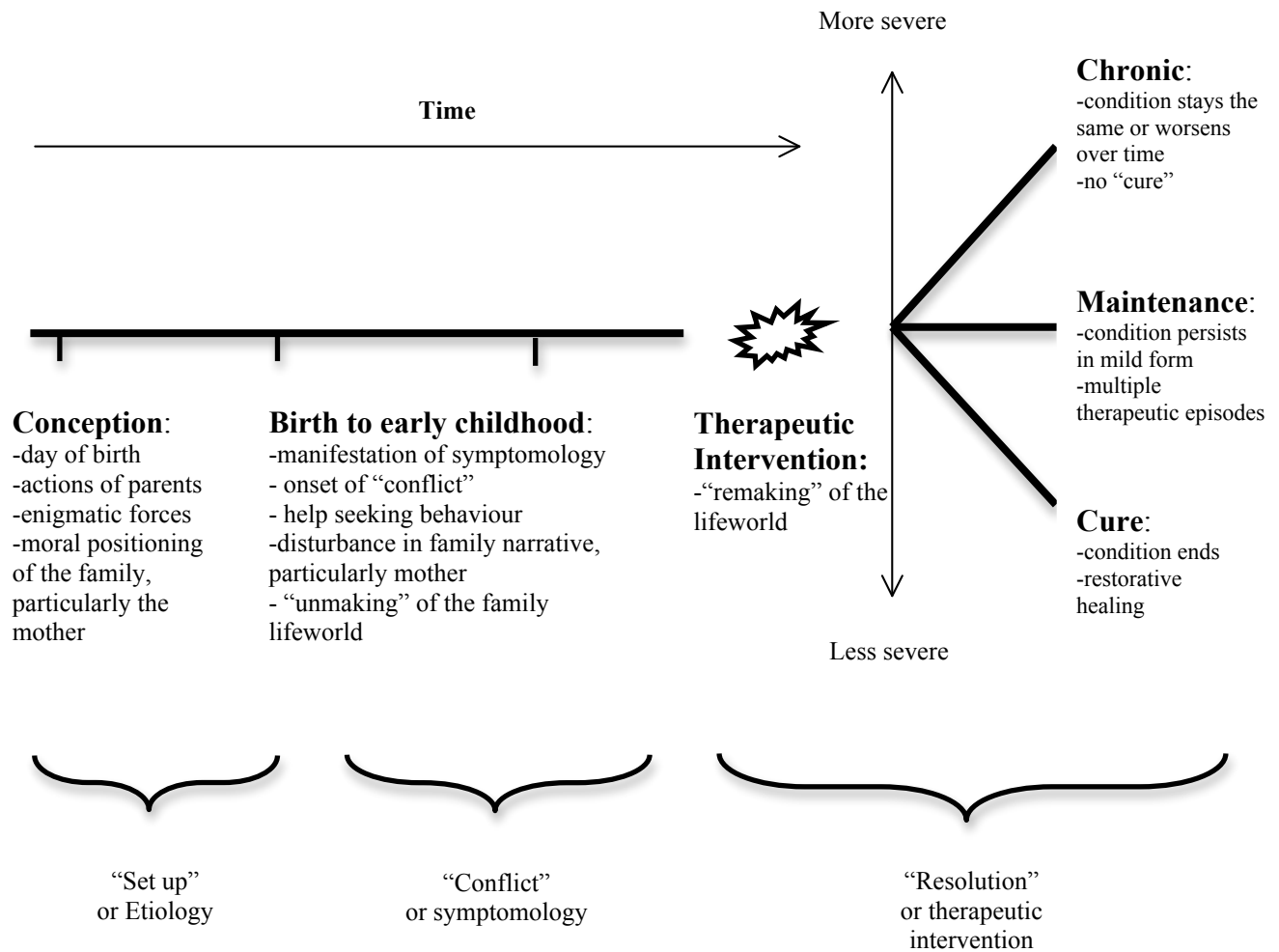
Childhood / neurological disorders. Of the 17 “mental” illness conditions recognized by the Q’eqchi’ healers, three fall within the broad narrative genre of “Childhood / neurological disorders.” Table 5 outlines these conditions including the main etiological attributions, symptomology and treatment approaches. Figure 2 shows the general prototypical plot forms or general “narrative genre” of these conditions.

In Table 5 the numbers in brackets represent the frequency with which the healers mentioned that cause, symptom, or treatment approach within the interviews. This number is collapsed across the healers and represents the number of times it was mentioned during the 94 interviews and conversations. For each condition, the healers attribute multiple causes, symptoms and treatments. For the illness conditions under this “narrative genre,” there are eight different causes invoked across the three illness categories; while some are unique to this genre others appear in more than one. These eight causes are: *maatan* or day of birth; actions of parents; changes in temperature; already in blood (i.e., heredity); thinking too much; failure to seek permission; spirit “attacks”; and spontaneous. In total, these eight causes are mentioned 32 times, 23 of which are related to the *maatan* or day of birth of the individual, actions of the parents during prenatal stages of development, or the condition of being already in the blood during the time of birth. This represents 72 percent of the total causal attributions for these conditions, a significant pattern in the healers’ narrative descriptions. The other prominent pattern within this genre is that each of the conditions begins in early childhood or at birth and remains with the individual throughout life unless interventions at an early age occur.

Table 5: Childhood/neurological narrative genre of mental disorders					
Illness category (Q'eqchi')	Illness category (English)	Etiology	Symptomology	Treatment	Demographic
<i>Sachk ch'ool</i> ^{8.2}	Memory loss OR "retardation"	Mataan / day of birth (3)	Learning difficulties (3)	Prayer (5)	Begins in childhood
		Spirit "attack" (1)	Memory loss (3)	Medicinal plants (5)	
		Thinking too much (1)	Improper thinking (3)	Awat (4)	
		Already in blood (1)	Incoherent speech (2)	Ceremony (3)	
		Failure to seek permission (1)	Retardation (2)	Use of 13 flowers (2)	
		Spontaneous (1)	Acting like a drunkard (1)		
<i>Ch'i' ch'i' il</i> ^{6.6}	Stressed OR miserable person	Mataan / day of birth (5)	Bodily Irritation (5)	Prayer (5)	Children only
		Changes in temperature (3)	Excessive heat (3)	Medicinal plants (5)	
		Actions of mother/parents (3)	Crying (3)	Awat (4)	
		Already in blood (2)	Difficulty eating (2)	Ceremony (4)	
		Spirit "attack" (1)	Fever (2)		
			Worries (1)		
<i>Awat</i> ^{10.0}	Illness of the moon	Actions of mother/parents (5)	Excessive heat (3)	Prayer (5)	Children only
		Mataan / day of birth (4)	Crying (3)	Medicinal plants (5)	
		Changes in temperature (1)	Difficulty eating (2)	Ceremony (4)	
			Fever (2)	Awat (1)	
			Acting like a drunkard (1)		
			Retardation (1)		

Note: The numbers in brackets represent the frequency with which the healers mentioned that cause, symptom, or treatment approach within the research interviews and conversations. This number is collapsed across the five different healers. The different categories that fall under etiology, symptomology, treatment and demographic can also be understood as the different themes that arose for each condition. Thus, this table allows an examination of the themes that emerge within a single illness category or within the overall “narrative genre.” The number in superscript above the condition name is the consensus score developed from Table 4.

Figure 2: General plot structure of Childhood / neurological disorders



The plot structure of the Childhood / neurological disorders genre begins before the birth of the individual. The events leading to these conditions originate at the time of conception, during the prenatal formation of the individual where the cosmic forces of the universe influence and interact with this period of a person's development. "It all depends on the moon and the stars on which you were born," Manuel Choc suggested while describing the onset of *awas*. Similarly with *ch'i' chi'i' il* Francisco explained, "That comes from birth, they have a negative mind. Some born in like [the months of] *Tijax* and *Imox*.²⁹ It's the day of the sea and the seas have rough and big waves. It's the same as a person. He will have some difficult times, some roughness like the waves." According to Francisco, if someone is born on a strong number in the months of *Tijax* or *Imox*, days which reflect the tidal qualities of the sea, the child will take on those characteristics and be temperamental and miserable, moving in and out of turbulent behaviours. Thus, a central agent in the story of these conditions is the day on which someone is born, their *maatan*, the enigmatic cosmic powers associated with each day name in the 260-day Maya calendar.

The illness condition of Paulo described in the opening section of this chapter is understood or "emplotted" by Francisco and the other members of the Q'eqchi' Healing Association as a form of *sachk ch'ool* (Mattingly, 1994). The term "*sachk*" refers to the condition of being "lost," as in being lost in the forest and in need of a guide. As mentioned in Chapter Two, the Q'eqchi' term "*ch'ool*" refers to the "soul" of the person, but is not described during discourses of *sachk ch'ool* as signifying the "spirit" as in "spirit loss." Rather, the discussion is focused more on a generalized notion of "life," a way of being that is "lost" when experiencing this condition due to the improper functioning of the mind. Within *sachk ch'ool*, "The person will not be talking properly or he will be acting like a drunken person because he

²⁹ This is a reference to the months in the Maya calendar. See Chapter Two or Appendix A for more details.

had lost his mentality, they will be totally lost (*sachk*) or at times when they speak it doesn't make any sense," Francisco described. In a similar way, Manuel Choc suggested that "anybody can get it [*sachk ch'ool*], sometimes the children are born retarded,³⁰ whereby the mind would not be functioning properly, the face would be down, and they will have difficulty in learning at school." As illustrated with the case of Paulo, this conditions can be severely debilitating leaving the individual at extremely low levels of social functioning.

Ch'i' chi'i' il and *awas* are closely related to *sachk ch'ool*, yet are still recognized as distinct conditions. The Q'eqchi' term "*ch'i' chi'i'*" signifies a bodily state of irritation or being miserable, when the body (*cha'al*) is not happy. The term "*il*" simply means the person who is experiencing this state. The term *awas* has no direct translation in English but can be understood as the manner in which one or more properties, characteristics or traits of an object are taken on by another. This is a kind of mystical transference or bonding of properties between objects, animals or people in the local environment. Signifying the influence of cosmic forces and the day in which someone is born, *awas* is typically translated as the "illness of the moon." The "illness" aspect of this condition, then, reflects the state in which negative or undesirable characteristics are taken on, bonded to or manifest within a particular individual. In a similar way to *sachk ch'ool*, *awas* is described as a kind of generalized difficulty in cognitive ability. "Sometimes with this condition it is just the way we are born," Emilio noted, "for instance if you are sending one of your children to school they may not have interest in doing work in class, may have difficulty learning." In *ch'i' chi'i' il* the child "won't be feeling well, he's always stressed out," Francisco explained. "The child is just stressful, crying, fighting and won't be able to eat," Emilio added, "Like when he sees his food, he would just reject it and cry." Or later Lorenzo

³⁰ Here during the interview Manuel used the term "*sachk*" which Thomas Caal translated to English as "retarded."

suggested that “When it’s [*ch’i’ chi’i’ il*] in a child he or she will just be crying and crying, because the child will be feeling heat in the body.”

What emerged during *aj iloneleb*’ descriptions of this “narrative genre” was a story that blurred across DSM-V categories of “Neurodevelopmental Disorders.” These conditions are defined in the DSM as “disorders that manifest early in development, often before the child enters grade school, and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning” (APA, 2013, p. 31).³¹ Such conditions typically include autism spectrum disorders (ASDs), a generalized notion of intellectual or learning disorders, motor disorders, Down Syndrome (DS), or mental retardation (MR). Both the healers’ descriptions and DSM categories narratively relate insofar as they begin at birth and are, therefore, usually chronic, neurological conditions lasting throughout life. Interestingly, the Q’eqchi’ healers also note that *sachk ch’ool* in particular can leave an individual with some heightened cognitive or intellectual abilities, as Emilio stated: “There are people that are like that, really good at math or drawings, the person can continue that expertise in life.” In addition, although the main discourse of this condition was centered on children, there were also occasional suggestions that *sachk ch’ool* can develop among elderly people. “Sometimes you can get it when you are old and sometimes kids are born with it,” Manuel Choc described. In these cases, “*sachk*” referred more specifically to the memory loss of a person and, thus, suggests possible connections with narratives related to Alzheimer’s or dementia, conditions described as the degenerative capabilities of the brain due to “age-related” concerns.³²

³¹ The intention here is not to present DSM or biomedical perspectives as validation for the Q’eqchi’ understandings of mental illness and disorder. Rather, DSM categories are used as a loose “heuristic” to promote a common language for cross-cultural conversations and dialogue. See page 31 for more details.

³² Although this research reveals a “narrative genre” clearly focused on “childhood” conditions, it is interesting to note that there is no specific narrative genre focused on the elderly.

There are also powerful moral discourses invoked during the narratives of these conditions that are not centered on the child, but rather the roles of the parents, family, or community members. According to the Q'eqchi' healers, children are largely outside the realm of moral responsibility, not having yet been moralized and socialized into the community. Thus, when children are born with certain conditions resembling mental retardation, it is the parents, and particularly the mothers, that are morally responsible for the onset of the condition. "That [*sachk ch'ool*] illness happens when the mother is a bad woman or she may hate other people," Emilio suggested. Or later Manuel Baki reasoned, "When the child gets *awas* it's because the mother don't like the scent of certain things and hates something or someone. Then the baby would directly be born with that effect." As Manuel Baki further described for *ch'i' chi'i' il*, "Sometimes they get that sickness when they are born because when a woman is pregnant they might go for a walk at night and that is what causes them to get that sickness." In this way, how the parents, and particularly mothers, behave and treat others in the community, and how they react to situations during conception and gestation periods are risk factors for the onset of the illnesses in the child. Whether parents start a conflict with a neighbour, walk late at night, or are frightened by an animal, the child will be born on a particular day that bestows characteristics onto the child. The mother's sins, *aj iloneleb'* often remark, are shown in the child. These childhood disorders can, therefore, be conceptualized from one perspective as a Q'eqchi' explanatory model regarding why some children are born with mental disorders or conditions and others are not. The locus of moral causation is situated in the actions of the mother and close family members. The role of *aj iloneleb'* in these cases, then, is to restore the moral order by ceremoniously placating the spirits and asking for forgiveness on behalf of the mother and family.

In Paulo's case, Francisco suggested that Paulo's mother was frightened at the sight of a monkey around the time of conception. The qualities and characteristics of the monkey, then, have been transferred to Paulo during prenatal development and produced the constellation of symptoms referred to as *sachk ch'ool*. In later stages of treatment with Paulo, Francisco spent many weeks searching the Maya jungles for the bones of a deceased monkey. These remnants were used in healing ceremonies to alter the effects of Maria's fright when originally seeing the monkey. Although no direct communication between Francisco and Maria occurred regarding this aspect of Paulo's treatment, Maria was also involved in several therapeutic encounters over a period of three months.

These conditions, more so than any others, are understood to be chronic neurological conditions that are with a person through life, although opinion as to severity and chronicity of these conditions can vary among *aj iloneleb'*. As illustrated in Figure 3, the "resolution" aspects of this narrative genre (i.e., its prognosis) have different trajectories based on the unique experiences of each family and the severity of the condition. The most severe conditions, like those of Paulo, which involve brain damage or neurological abnormalities, are presented by the healers as the most chronic. In this plot, the parents are forced to adapt to the condition and, after the initial search for a cure, the family and patient come to accept, to varying degrees, what has been given to them. In a sense, acceptance of the patient is their therapeutic intervention, and they work to ensure that the patient's life is as harmonious as possible. In less severe cases, individuals will require regular patterns of therapeutic intervention throughout their life to ensure the condition is under control and does not manifest in a debilitating manner. Finally, in the least severe of these cases, the healers suggest that a full "cure" is possible through the intervention of

“restorative” based healing (Waldram, 2013). In this plot the condition is completely gone and the patient’s symptoms entirely abated.

Illnesses related to “Fright.” Of the 17 “mental” illness conditions recognized by the Q’eqchi’ healers, three fall within the broad narrative genre of “Fright.” Table 6 outlines these conditions including the main etiological attributions, symptomology and treatment approaches. Figure 3 shows the prototypical plot forms or general “narrative genre” of these conditions.

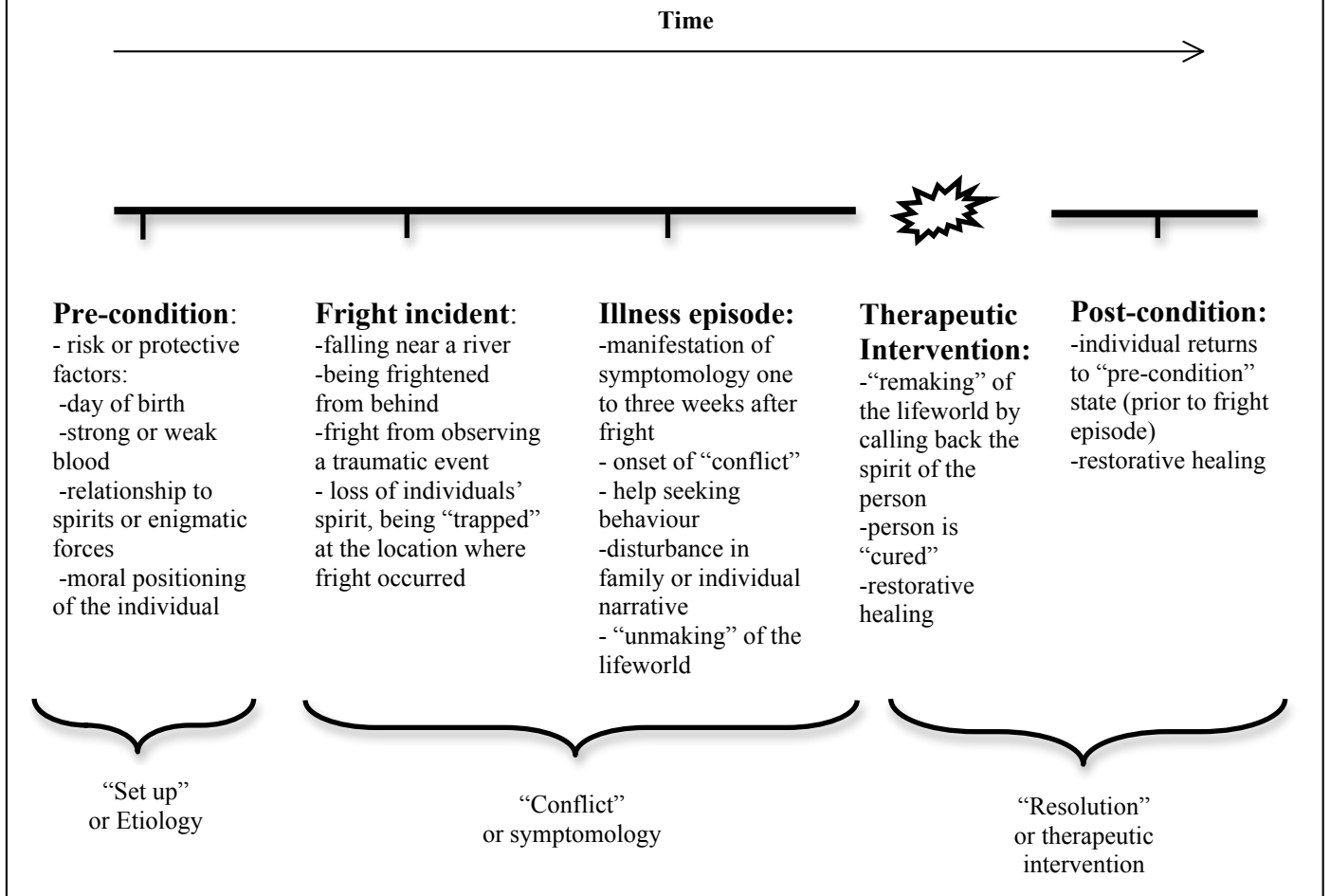
In Table 6 the numbers in brackets represent the frequency with which the healers mentioned that cause, symptom, or treatment approach within the interviews. This number is collapsed across the healers and represents the number of times it was mentioned during the 94 interviews and conversations. For each condition, the healers attribute multiple causes, symptoms and treatments. For the illness conditions under this “narrative genre,” there are eight different causes invoked across the three illness categories; while some are unique to this genre others appear in more than one. These eight causes are: fright; *maatan* or day of birth; thinking too much; spirit “attack”; changes in temperature; already in blood; witchcraft; and actions of parents. In total, these eight are mentioned 26 times, 13 of which are related to “fright.” This represents 50 percent of the total causal attributions for these conditions, an important pattern in the healers’ narrative descriptions. It is also important to note that some of the causes listed here such as “*maatan*/day of birth,” “actions of mother/parents,” or “already in blood” are better described as pre-condition factors, that which predisposes an individual to succumb to frightening experiences in the face of other etiological factors. Another prominent pattern within this illness narrative genre is that the symptomology of these conditions also involves fear, worry or some kind of excessive paranoia. Indeed, one of the primary means by which *aj iloneleb*’ diagnose these conditions is through the blood pulsating in a “fearful” manner. Finally, these

conditions involve the unique healing approach of “smoking” the patient and “calling back the spirit” of the patient, two therapeutic techniques described to alleviate the worry and fearful symptoms of the patient and which are unique to this narrative genre. The prayer called “*b’oqok mu*,” translating roughly as “the prayer that calls back the spirit of the person,” is also uniquely used with and for these conditions, although the treatment approach for the conditions under the spirit “attack” narrative genre occasionally include this prayer.

Table 6: "Fright" narrative genre of mental disorders					
Illness category (Q'eqchi')	Illness category (English)	Etiology	Symptomology	Treatment	Demographic
<i>Xiw xiw</i> ^{6.2}	Anxiety, worry, OR always afraid	Fright (3)	Fearful/paranoid (3)	Prayer (5)	Adults and youth only
		Mataan / day of birth (2)	Rumination (3)	Medicinal plants (5)	
		Thinking too much (2)	Restlessness (1)	Awes (3)	
		Already in blood (2)	Cold hands and feet (1)	Smoking/burning hair (3)	
		Actions of mother/parents (2)	Fever (1)	Ceremony (2)	
		Witchcraft (1)	High blood pressure (1)	Calling spirit back (1)	
		Spirit attack (1)			
<i>Kaanil</i> ^{12.2}	Fallen by fright OR "soul" loss	Changes in temperature (1)			Mostly children, some adults as well
		Fright (from falling) (5)	Afraid (4)	Prayer (5)	
		Already in blood (1)	Diarrhea (4)	Medicinal plants (5)	
			Vomiting (4)	Awes (4)	
			Pale complexion (3)	Ceremony (4)	
			Excessive tiredness (3)	Calling spirit back (4)	
			Headache (1)	Smoking the person (4)	
<i>Oksinb'il kaan</i> ^{8.0}	Fright illness	Fever/chills (1)			Any person of any age
		Fright (from behind) (5)	Afraid (4)	Prayer (5)	
		Already in blood (1)	Diarrhea (4)	Medicinal plants (5)	
			Vomiting (4)	Awes (4)	
			Pale complexion (3)	Ceremony (4)	
			Excessive tiredness (3)	Calling back the spirit (4)	
			Headache (1)	Smoking the person (4)	

Note: The numbers in brackets represent the frequency with which the healers mentioned that cause, symptom, or treatment approach within the interviews and conversations. This number is collapsed across the five different healers. The different categories that fall under etiology, symptomology, treatment and demographic can also be understood as the different themes that arose for each condition. Thus, this table allows an examination of the themes that emerge within a single illness category or within the overall “narrative genre.” The number in superscript above the condition name is the consensus score developed from Table 4.

Figure 3: General plot structure of “Fright” conditions



Note: Although depicted here as a horizontal line, the plot structure of “Fright” conditions is best conceptualized as cyclical in nature.

All of the conditions classified under the narrative genre of “Fright” emerge as a result of some kind of frightening experience. In *aj iloneleb*’ descriptions, however, there are also many subtle allusions to a pre-condition state, such as the risk and protective factors that contribute to the onset of the illness. It is here that aspects of Q’eqchi’ cosmovision come to bear most directly on the plot of the fright illnesses (i.e., the individual’s relationship with the spirits of the Mountains and Valleys, the moral contours of their personhood, and their *maatan* or day on which they are born). The multiple ways in which these “pre-condition” factors coalesce in a particular individual, family and community life, will determine, to a great extent, whether or not the person will, at some point in their lives, become ill due to fright.

Without question, the fright episode is the point around which the plot of this narrative genre unfolds. It is the inciting incident or catalyst that propels and shapes the illness narrative. The Q’eqchi’ *aj iloneleb*’ recognize many ways in which an individual can become frightened, the general term for which is referred to as *xiwajenak*, translating as the state or condition of being frightened. Within this broad term are several distinct conditions that depend on the way in which the person is frightened. *Kaanil*, for instance, which is likely the most common illness within this narrative genre and has the highest consensus score, specifically refers to someone who has fallen by a river and become ill as a result. Since this is the fright illness most common among the Q’eqchi’ healers, *kaanil* can also be used as a general term for fright illness conditions synonymous with *xiwajenak*. More specifically, we could say that the root “*kaan*” here is synonymous with *xiwajenak*, both signifying the state or condition of being frightened.

Oksinb’il kaan is a condition closely related to *kaanil*, except that it is caused specifically by being frightened from behind. *Aj iloneleb*’ also describe cases where individuals have become afraid at the sight of seeing the ghost of a relative that had passed on. Thus, this condition can

occur as a result of “supernatural” as well as natural events. *Xib'emb'il* is another Q'eqchi' term that is used to describe this fright condition, a kind of fright induced from another person or community member who does something unexpected. Different illness names are attributed to different etiological agents, and although *kaanil* and *oksinb'il kaan* are nearly identical in symptomology, they are recognized as separate conditions requiring slightly different healing approaches based solely on how the person became frightened (i.e., etiology).

The last condition that falls within this narrative genre is *xiw xiw*, and is etymologically related to *xiwajenak*. Although involving fright as a core aspect of the illness narrative, this condition is slightly different from *kaanil* and *oksinb'il kaan* insofar as it is more chronic and severe in nature. The onset of *xiw xiw* is not described as sudden. Rather, it comes on gradually and then impairs the individual to such an extent that he or she becomes afraid of nearly everything (i.e., other people, animals, leaving the house, loud noises, or travel). This condition is reminiscent of Generalized Anxiety Disorder (GAD) in the DSM-V, although, as can be expected, the cultural undercurrents and interpretive aspects of the condition are somewhat unique. It does, however, have a distinct onset usually related to the “attack” from a spirit. In this way, it relates to the narrative genre of spirit “attacks” as illustrated in Figure 1, yet is distinctly characterized with the state of being afraid. As a result, *xiw xiw* is the most serious condition within the narrative genre and the most difficult to treat. This condition also has a low consensus score because only Francisco and Emilio recognize this as a distinct mental illness.

After the “fright” episode, it generally takes between one and three weeks for an individual to become ill. This is because the individual's *mu* (i.e., spirit), that is trapped at the location where the fright occurred, is outside and away from the person. This separation between the person's spirit and body gradually creates the symptoms associated with this illness

condition. “The person falls down and gets frightened,” Manuel Baki explained, “The spirit is lost and it causes fever. It’s in the river and streams that the spirit is lost.” “The person will be experiencing lots of frights and the blood will re-circulate with frights as well and that person will have fever and loose stools,” as Manuel Choc described regarding *kaanil*. “The *kaanil* affects the blood and the person will begin to get frightened and then the person will start to vomit, will be shamed, and will be tired” added Francisco. Because the spirit is trapped at the site where the fright incident occurred, the patient’s actions and ability to perform normal behaviours slowly decline. What is “lost” in these conditions is not only the *mu* as it is trapped away from the body, but also a generalized way of being-in-the-world, a normalized and moralized mode of action-in-place (Kahn, 2006).

These fright conditions mimic categories presented in DSM-V resembling, at times, the general notion of “Anxiety Disorders,” or, more specifically, Generalized Anxiety Disorder (GAD) for *xix xix*, or Post-Traumatic Stress Disorder (PTSD) for *kaanil* and *oksinb’il kaan*. According to the DSM-V, anxiety is defined as “the apprehensive anticipation of future danger or misfortune accompanied by a feeling of worry, distress, and or/somative symptoms of tension” (APA, 2013, p. 818) and involves “features of excessive fear” related to “behaviour disturbances” (APA, 2013, p. 189). Although there are some similarities in “Fright” narrative genres and anxiety-type conditions, there is distinction insofar as anxiety primarily involves anticipated future threats and fear involves emotional responses to real or perceived threats. As opposed to this formulation, fright conditions presented here involve a preceding frightening episode followed by an illness state and change in behaviour. As such, the “Fright” narrative genre is perhaps more closely related to “Trauma and Stressor-related Disorders” in the DSM-V

wherein “exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion” (APA, 2013, p. 265).

In addition, these “Fright” conditions are also reminiscent of the general narrative structure of “*susto*” as presented in the DSM’s “Glossary of Cultural Concepts of Distress.” As a “folk illness” prevalent among Latinos in the southern United States, Mexico, Central America and parts of South America (Weller, Baer, Garcia, & Rocha, 2008), *susto* involves an illness that is associated with “a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles” (APA, 2013, p. 836). This description in the DSM, although brief and somewhat essentialist in its language, is related to the narrative structure of these “Fright” genres, especially the condition of *kaanil*. Indeed, the term “*susto*” is occasionally used by the Q’eqchi’ healers and translators to describe these “fright” conditions, having learned the term from their Spanish compatriots and other social science researchers working in the area.

Therapeutic interventions within this narrative genre center on restoring the patient to the pre-illness condition; that is, to call back the spirit and thereby eliminate the symptomology of the condition. For *kaanil* and *oksinb’il kaan*, this is generally a straightforward therapeutic intervention involving the “calling back of the spirit of the person” in a healing ceremony involving prayers, candles and herbal medications. Chapter Four outlines this process in more detail. For *xiw xiw* the treatment and therapeutic narrative is slightly more complex and based on the severity of the condition, in some cases involving elaborate attempts to retrieve some hair from the animal that caused the frightening event. Overall, however, the healers’ descriptions of these conditions centre on a notion of “cure.” All *aj iloneleb’* recognize that the condition of being afraid, even when driven to pathological levels, can be cured through strategic intervention

and healing techniques. Thus, the resolution of this narrative genre is generally clean and simple when compared to the multiple plot endings within the childhood or neurological disorders. In this way, the general plot structure of the fright conditions is more cyclical than linear; the goal is to return to the pre-fright episode state. Generally speaking, it is a relatively easy and fluid “restorative” healing process (Waldram, 2013).

“Thinking too Much.” Seven of the 17 “mental” illness conditions recognized by the healers fall within the broad narrative genre of “Thinking too much.” Table 7 outlines these conditions while Figure 4 shows the general prototypical plot forms or general “narrative genre” of these conditions.

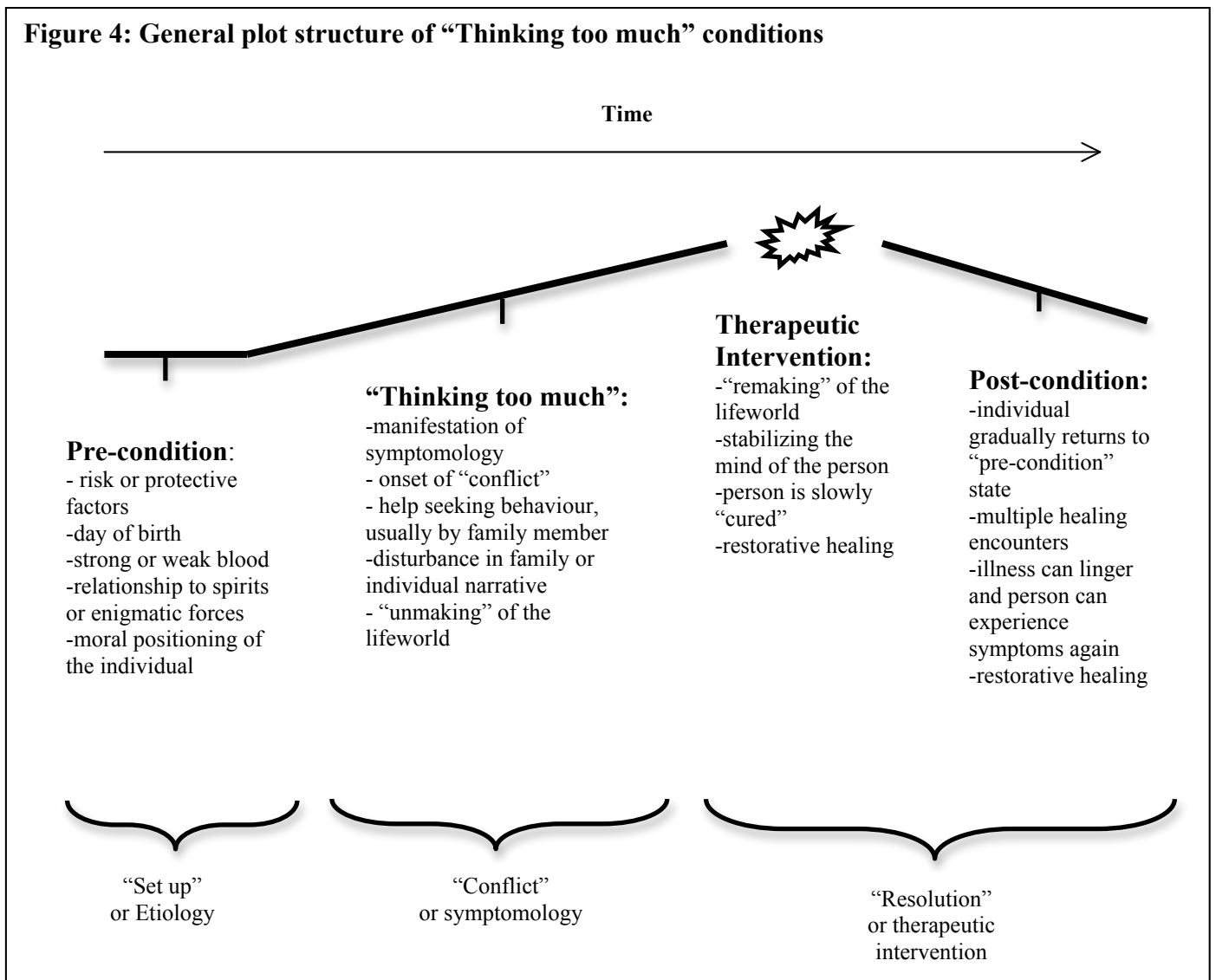
In Table 7 the numbers in brackets represent the frequency with which the healers mentioned that cause, symptom, or treatment approach within the interviews. This number is collapsed across the healers and represents the number of times it was mentioned during the 94 interviews and conversations. For each condition, the healers attribute multiple causes, symptoms and treatments. For the illness conditions under this “narrative genre,” there are 13 different causes invoked across the seven illness categories; while some are unique to this genre others appear in more than one. These 13 causes are: thinking too much; changes in temperature; in the air; from other conditions; spirit “attacks”; *maatan* or day of birth; witchcraft; already in blood (i.e., heredity); death of loved one; marital problems; financial troubles; and fright. In total, these 13 are mentioned 77 times, 47 of which are connected directly to “thinking too much” or related etiological factors such as witchcraft, death of a loved one, marital problems, family problems or financial troubles. This represents 61 percent of the total causal attributions for these conditions, an important pattern in the healers’ descriptions. In terms of treatment approaches, another important pattern for this narrative genre is that all of these conditions use

the prayer “*k’ochob’ank*” translating roughly as “the prayer to stabilize the person’s mind and thinking.” In addition, these are the only conditions that use a kind of therapy involving an array of flowers. It is said that the scent of various flowers can help “stabilize” the thinking of the person and are hence useful for “thinking too much” conditions.

Table 7: "Thinking too much" narrative genre of mental disorders					
Illness category (Q'eqchi')	Illness category (English)	Etiology	Symptomology	Treatment	Demographic
<i>Tib'l jolom</i> ^{8.6}	Headache	Thinking too much (4) Changes in temperature (2) In the air (1) From other conditions (1)	Headache (5) High blood pressure (4) Red face (4) Fever (2)	Prayer (5) Medicinal plants (5) Awax (1)	Any person of any age
<i>Chiqwual xjolom</i> ^{5.8}	Illness of the hot head	Spirit "attack" (2) Mataan / day of birth (2) Changes in temperature (2) Thinking too much (2) Witchcraft (1) Already in blood (1)	Excessive heat (4) Anger (2) Restlessness (2) Worries (2) Red face (2) High blood pressure (2) Difficulty sleeping (2) Aggressiveness (1) Headache (1)	Prayer (5) Medicinal plants (5) Awax (3) Ceremony (2)	Any person of any age
<i>Po'ol k'a'uxl</i> ^{8.2}	Spoiled mind	Witchcraft (4) Thinking too much (4) Spirit "attack" (1) Already in blood (1)	Feeling sad (5) Excessive worries (5) Suicide (3) Tiredness (2) Apathy (2) Mild hallucinations (1)	Prayer (5) Medicinal plants (5) Awax (4) Ceremony (3)	Any person of any age
<i>Rahil ch'ool</i> ^{10.8}	Sadness of the soul OR extreme depression	Thinking too much (5) Death of a loved one (4) Marital problems (4) Financial troubles (3) Family problems (3) Fright (1)	Feeling sad (5) Excessive worries (5) Suicide (3) Tiredness (2) Apathy (2) Mild hallucinations (1) Lack of appetite (1) Inability to speak (1)	Prayer (5) Medicinal plants (5) Ceremony (3) Awax (2) Use of 13 flowers (2)	Adults and youth only
<i>Aj ookil</i> ^{7.2}	Insomnia	Thinking too much (3) Mataan / day of birth (3) Witchcraft (1) Already in blood (1) Changes in temperature (1)	Difficulty sleeping (5) Restless (2) suicide (2) excessive heat (2) Talking to themselves (2) Fever (1) High blood pressure (1) Muscle & Joint pain (1)	Prayer (5) Medicinal plants (5) Awax (1) Blood letting (1)	Adults and youth only
<i>Wax ru</i> ^{10.2}	Extreme craziness	Thinking too much (4) Spirit "attack" (2) Witchcraft (1) Already in blood (1) From other conditions (1)	Running away (5) Rumination (3) Violent out bursts (3) Acting "crazy" (3) Screaming/shouting (3) Excessive strength (2) Red face (2) Acting like a drunkard (1) Talking to oneself (1) Headache (1)	Prayer (5) Awax (5) Medicinal plant (5) Ceremony (2) Smoking (1)	Any person of any age
<i>Waxk'ay</i> ^{9.4}	Milder craziness, and/or mood swings	Thinking too much (4) Spirit "attack" (3) Witchcraft (1) Already in blood (1) From other conditions (1) In the air (1)	Hallucinations (4) Running away (4) Talking to oneself (3) Red face (2) Paranoid (2) Restlessness (2) Acting like a drunkard (1) Suicide (1) Feeling sad (1) Headache (1)	Prayer (5) Awax (5) Medicinal Plant (5) Ceremony (1) Specific time (1)	Any person of any age

Note: The numbers in brackets represent the frequency with which the healers mentioned that cause, symptom, or treatment approach within the interviews and conversations. This number is collapsed across the five different healers. The different categories that fall under etiology, symptomology, treatment and demographic can also be understood as the different themes that arose for each condition. Thus, this table allows an examination of the themes that emerge within a single illness category or within the overall “narrative genre.” The number in superscript above the condition name is the consensus score developed from Table 4.

Figure 4: General plot structure of “Thinking too much” conditions



Note: The gradual incline and decline depicted here represents the slow accumulation of illness symptoms over time as well as the gradual decline of symptoms and multiple healing encounters generally required for these conditions.

The term “thinking too much” or *mas k’a’uxl’ac* in Q’eqchi’, is an idiom frequently used by *aj iloneleb’* to signify a general state of unhealthy thought or patterns of thinking that are negative or harmful to an individual. It is also, therefore, a general term for what may be considered “cognitive” illnesses in Western contexts insofar as they, more directly and explicitly, are known to negatively impact the mind, and in a sense, “only” the mind of an individual.³³ These are the only conditions recognized by the healers to be illnesses of “thinking.” As noted in Chapter Two, however, the Q’eqchi’ notions of “mind” and “heart” are closely related, and often the “thinking” of the individual is expressed in the heart as well. In Q’eqchi’ parlance emotions (*xch’ool*) are expressions of both the heart (*aam*) and soul (*ch’ool*), recognized as an external communication of the internal spirit, and also the way in which one behaves in the world. In this way, these “thinking too much” conditions also closely reflect a Q’eqchi’ notion of “mood” disorders insofar as pathological thinking can alter one’s mood or emotional well-being. It is not surprising, then, that many descriptions of the various conditions within this narrative genre significantly engender a wide range of emotional idioms such as anger, frustration or excessive sadness. With the exception of “fear,” the sole emotional idiom of the “Fright” narrative genres which is rarely invoked for “thinking too much” conditions, all “mental” illnesses within this genre involve emotional expression.

The origins of illness within this narrative genre begin with a problem or event that triggers the onset of “thinking too much.” As can be seen from Table 7, there are many etiological pathways to the state of “thinking too much.” Witchcraft, family troubles, financial problems, excessive heat, or the death of a loved one are some of the ways in which the content of one’s thinking can be driven to a pathological level. “One can suffer from headache [*tib’l*

³³ Albeit even when we speak of “only” the mind, it must be recognized that most conditions involve somatic and spiritual issues as well. In Q’eqchi’ metaphysiology these aspects of the person are deeply interrelated as noted in Chapter Two.

jolom] because he has so many negative things on his mind and thinking too much [*mas k'a'uxl'ac*],” explained Francisco. Notably, “thinking too much” is described as both a state that leads to illness and a symptom. It could be said that it is the “content” of the “thinking too much” or the negative thought patterns that are relevant in understanding the different conditions within this narrative genre and the reason why each condition is given a different name. Within this plot structure, the onset of the condition is characterized by a slow accumulation of risk factors or the absence of protective factors; this is quite different from the story regarding “fright” conditions. The cause of the condition can be the loss of a loved one or community member (as will be seen by Serena’s case in Chapter Five). However, the symptoms are not recognized to begin immediately; it may take time in addition to other factors before the individual’s state becomes interpretable as pathological and warranting therapeutic intervention. From the Q’eqchi’ healers’ perspectives, these predisposing factors primarily involve one’s relation to the spirits of the Mountains and Valleys, the moral economy of permission and one’s *maatan* as outlined in Chapter Two. However, there are other factors that influence the specific illness narratives of each condition, including relationships with community members, actions of parents or siblings, or a general notion of strength or weakness related to the concept of personhood and one’s day of birth (i.e., *maatan*).

Conditions like *tib'l jolom* and *chiqwual xjolom* are roughly translated as “pain in the head” and “heat in the head,” respectively. This heat is semantically related to emotional states such as anger or frustration; patterns of thinking that, when carried to excess, lead to pathological states. The “content” of thinking too much here is usually based on the stress of the headache and less on social or environmental stressors. However, these conditions can also be the result of “thinking too much” about one’s financial situation or a problem with one’s marriage or

community life. As Lorenzo described *tib'l jolom*, “let’s say that a person wants to be with a woman so he will start to think about that woman too much and he eventually gets headache.” Or as Manuel stated, “whenever somebody has a bad attitude towards others they are more susceptible to getting headache, because all they think about is negative things. The blood temperature rises and the person’s face turns red.” Similarly, Francisco explained regarding *chiqwual xjolom*, “the main cause of this sickness is because the person might be thinking of having more education but can’t afford it. So in that case the blood begins to get hot and the person would be upset.” As shown in Table 7, the symptoms and patient experiences often involve high blood pressure or hypertension, fever, nausea, difficulty sleeping and, in extreme cases, a kind of dangerous aggressiveness that can endanger oneself and the community.

The illness *rahil ch’ool* translates as “sadness of the soul” or “depression,” *ra* signifying the emotional state of sadness and *ch’ool* referring to soul, while also signifying their emotional state (as in how the soul is socially expressed to others). *Po’ol k’a’uxl* translates as “spoiled mind,” and although the symptomology is similar to *rahil ch’ool*, it is caused by the ill intentions of another or by witchcraft, and is thus given a separate name. *Aj ookil* translates as a “person who remains awake,” as in insomnia, and is closely related to *rahil ch’ool* and *po’ol k’a’uxl*. In some instances, it is described as a symptom of these conditions rather than a separate condition. As Manuel Baki described regarding a patient who became ill due to the loss of a loved one, “Maybe this person is sick. His worries get too much and he might say, ‘why he [family member] hasn’t died yet?’ He gets sad and his sickness is getting worse and then it turns to this sadness. He gets sleepy because of worries.” Notably, the symptoms for conditions like *rahil ch’ool* and *po’ol k’a’uxl* are nearly identical to conditions such as Major Depressive Disorder (MDD) presented in the DSM. Both involve an overwhelming degree of sadness, debilitating

lethargy, listlessness, suicidal ideation, fatigue, significant loss of energy, and diminished cognitive ability. “The person with this illness [*rahil ch’ool*], their blood will be really sad or moving slow, and the person will not be feeling well. He will be feeling sad that he has something in his mind,” outlined Lorenzo Choc. Or, as Francisco explained,

The *rahil ch’ool* affects the mind first because he or she is not thinking correct again. And then the heart is affected also. The person will not be feeling good and he will not be able to talk or eat because he is not feeling contented. I am saying that because the person that is been affected is always feeling sad and sometimes they try to kill themselves by hanging themselves or drinking chemicals. They do these things because they don’t understand what to do next. They try to kill themselves because of the sadness that they have.

The long-term result of pathological sadness is the taking of one’s life. This is an end to these conditions that is consistent among *aj iloneleb’*, positioning this condition close to the top of the continuum of consensus in Table 4 or the center in Figure 1.

Wax ru and *waxk’ay* are more serious and dangerous than the other conditions within this narrative genre, although the thread of “thinking too much” is predominant. The Q’eqchi’ term *wax* reflects behaviour that is “crazy.” The term can also be used for someone who is in a hurry or who, for example, comes into a house during a storm and is madly searching around for their rain boots. The term “*ru*” signifies the face of the person. Together, *wax ru* translates as “the person who is acting crazy,” or “the person who has crazy on their face.”

The Q’eqchi’ term “*k’ay*” translates as “the person who wants to sell something.” In the context of mental illness, *waxk’ay* signifies a person who is “selling craziness,” as in acting in such a way as to make others witness their crazy actions. For all healers in the QHA, these two conditions were described in a similar manner, except when descriptions were based on severity.

In this case, all healers separated these two conditions, suggesting that *wax ru* was more serious than *waxk'ay*.

The “content” of thinking too much with these two conditions is characterized by a kind of chaotic thinking and an inability to communicate or follow a conversation properly. These conditions can also involve severe hallucinations and feelings of wanting to “run away” from others, notions related to the DSM’s “running” taxon. Describing *wax ru* Emilio stated, “The person acts as a drunkard. The person might kill or hurt you because he is not conscious of what he’s doing. It’s really dangerous and he is stronger than everybody. The person can talk and get angry or they could even bite you.” Similarly, Manuel Choc suggested, “*wax ru* is really dangerous because this person won’t allow you to get hold of him. All he wants is to run into bushes, he screams and makes weird sounds.” “The person gets crazy,” he continued, “starts to talk to himself without sense, fights with family members, and shouts at people.” Regarding *waxk'ay* Lorenzo noted, “The person will have a headache, and will be thinking too much craziness, and the heart starts to have pain. Eventually the person will start to think of running away in the forest. That is the way this sickness occurs.”

These descriptions reflect an array of conditions presented in the DSM-V, specifically those referred to as “Schizophrenia Spectrum and other Psychotic Disorders.” These involve abnormalities in one or more of five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behaviour (including catatonia), and negative symptoms (APA, 2013, p. 87). Indeed, both *wax ru* and *waxk'ay* involve, to greater or lesser degrees, varieties of delusions, hallucinations, disorganized speech, and grossly disorganized behaviour. As such, *wax ru* and *waxk'ay* are described by the Q’eqchi healers to be among the most serious and dangerous cases to treat, requiring “special” knowledge and techniques in order

to properly return the person's thinking to "normal." As opposed to the biological and neurological discourse in the DSM, however, *aj iloneleb'* outline a wide range of etiological factors known to induce these forms of pathological thinking (see Table 7).

Throughout these "thinking too much" conditions, the cognitive content of *mas k'a'uxl'ac* is generally on some kind of social misfortune (i.e., problems with a spouse, boyfriend or girlfriend, financial troubles, the death of a close family or community member, or other generalized life stressors). The main actors in this narrative genre involve the family, community or social relations. Children are not typically able to suffer from these illness conditions since they involve general misfortune and complex social affairs. "Kids don't really get it," Emilio suggested regarding *rahil ch'ool*, "maybe from 14-16 years and older they can get this illness. Once you're not worried about anything you won't get this sickness but if you're worried, of course you can get it." Only adults are thought to understand complex social relations involved with these conditions and so they are the only ones susceptible to "thinking too much."

Therapeutic intervention and post-condition temporal points within the generalized "thinking too much" narrative structure are similar to "restorative healing processes" seen in "Fright" conditions (Waldram, 2013). However, they are marked by longer recovery times. The treatment is known to completely dissipate the illness if done properly and under the right conditions. Multiple treatment encounters are the norm, however, as symptom relief can take much more time. As Francisco suggested, "with *wax ru* it has its own prayer. Once the mind is altered, we smoke him and say a prayer called *k'ochob'ank*, whereby you ask the plants a favour so the mind stabilizes and the persons' thinking stabilizes." Similarly, as Manuel Choc related, "once the right healing is done, through the medicines and smoking the patient and calling on the plants, then the patient will get better." There are some instances where, if a condition is severe

enough, the healers recognize that a complete “cure” may not be possible and instead a kind of coping or “acceptance” must ensue. A softer ending to this plot structure can be observed, as stabilization of one’s thinking occurs slowly over several cycles of treatment. In most cases, this was observed to be one or two months as opposed to the weeks mentioned for “fright” conditions. Overall, however, *aj iloneleb*’ agree that a “cure” is possible even for complex cases of *wax ru* in which the patient is extremely aggressive, dangerous and constantly running into the forest. Even for these situations, *aj iloneleb*’ suggest that a complete elimination of the illness condition is possible and a return of the individual to normal day-to-day functioning can occur.

Spirit “attacks.” Of the 17 “mental” illness conditions recognized by the Q’eqchi’ healers, four fall within the broad narrative genre of spirit “attacks.” Table 8 outlines these conditions including the main etiological attributions, symptomology and treatment approaches; Figure 5 shows the general prototypical plot forms or general “narrative genre” of these conditions.

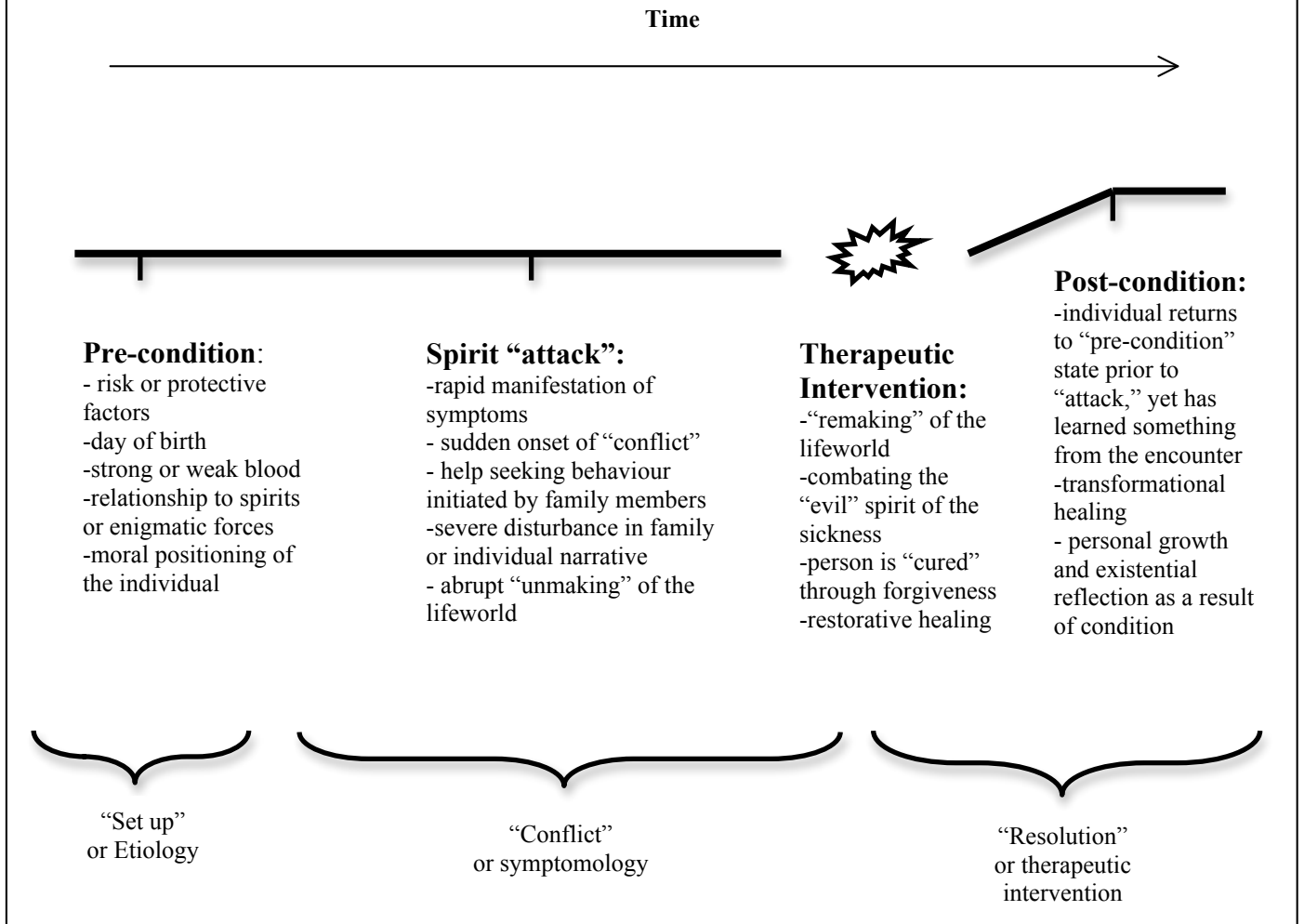
In Table 8 the numbers in brackets represent the frequency with which the healers mentioned that cause, symptom, or treatment approach within the interviews. This number is collapsed across the healers and represents the number of times it was mentioned during the 94 interviews and conversations. For each condition, the healers attribute multiple causes, symptoms and treatments. For the illness conditions under this “narrative genre,” there are 14 different causes invoked across the four illness categories; while some are unique to this genre others appear in more than one. These 14 causes are: spirit “attack”; in the air; already in the blood (i.e., heredity); thinking too much; fright; failure to seek permission; from other conditions; falling down; witchcraft; changes in temperature; maatan or day of birth; actions of parents; physical impact; and spontaneous. In total, these 14 causes were mentioned 34 times, 27

of which are related directly to spirit “attack,” a failure to ask for permission, or something in the “air” that “hits” the person, all of which are related to the ideology of spirit “attack.” This represents 79 percent of the total causal attributions for these conditions, an important pattern in the healers’ narrative descriptions. It is important to note that *k’axum xul* (i.e., snake bite) is also included in this narrative genre of mental illness since its description by the healers closely resembles *rilom tzuul* and *eet aj yahel*. *Sikirk* is also included in this narrative genre due to its related narrative structure involving contact with “spirits” or supernatural forces, yet this condition is somewhat separate from the others insofar as its symptomology primarily involves neurological or sensory-motor defects as opposed to direct “mental” disturbances. In this way, it is included under this narrative genre for similar reasons as *k’axum xul*. Finally, *eet aj yahel* is, at times, thought to arise from “Fright” conditions and is therefore located next to this narrative genre in Figure 1.

Table 8: Spirit "attacks" narrative genre of mental disorders					
Illness category (Q'eqchi')	Illness category (English)	Etiology	Symptomology	Treatment	Demographic
<i>Eet aj yajel</i> ^{11.6}	Falling down by evil spirit OR "epilepsy"	Spirit "attack" (9)	Falling down unconscious (8)	Prayer (5)	Any person of any age
		In the air (3)	Teeth clenched (3)	Medicinal plants (5)	
		Already in blood (2)	Eyes tolling back (3)	Awax (4)	
		Thinking too much (1)	Neck Twisted (3)	Ceremony (2)	
		Fright (1)	Twisting hands and lips (3)		
		Failure to seek permission (1)	Black and blue complexion (2)		
		From other conditions (2)	Trembling (1)		
		Falling down (2)	Fever/chills (1)		
<i>Rilom tzuul</i> ^{9.6}	Falling down by mountain spirit OR "severe epilepsy"		Pale complexion (1)		Any person of any age
		Spirit "attack" (5)	falling down unconscious (5)	Prayer (5)	
		Failure to seek permission (3)	Teeth clenched (4)	Medicinal plants (5)	
		In the air (3)	Eyes tolling back (3)	Awax (5)	
		Witchcraft (1)	Neck Twisted (3)	Ceremony (2)	
		Already in blood (1)	Twisting hands and lips (3)		
			Black and blue complexion (3)		
			Trembling (3)		
<i>K'axum xul</i> ^{10.2}	Snake bite		Fever/chills (2)		Any person of any age
		Spirit "attack" (5)	Fear and worry (4)	Prayer (5)	
		Failure to seek permission (2)	Excessive pain (3)	Medicinal plants (5)	
		Thinking too much (1)	Loss of movement (3)	Awax (5)	
			Paralyzation (2)	Extracting venom (5)	
<i>Sikirk</i> ^{6.8}	Numbness		death (1)	Ceremony (3)	Any person of any age
		Changes in temperature (3)	Numbness (4)	Prayer (5)	
		Spirit "attack" (2)	Immobility (3)	Medicinal plants (5)	
		Witchcraft (2)		Awax (3)	
		Already in blood (1)		Massage (3)	
		Mataan / day of birth (1)		Tying of bones (1)	
		Fright (1)			
		In the air (1)			
		Actions of mother/parents (1)			
		Physical impact (1)			
		Failure to seek permission (1)			
		Spontaneous (1)			

Note: The numbers in brackets represent the frequency with which the healers mentioned that cause, symptom, or treatment approach within the interviews and conversations. This number is collapsed across the five different healers. The different categories that fall under etiology, symptomology, treatment and demographic can also be understood as the different themes that arose for each condition. Thus, this table allows an examination of the themes that emerge within a single illness category or within the overall “narrative genre.” The number in superscript above the condition name is the consensus score developed from Table 4.

Figure 5: General plot structure of Spirit “attack” conditions



Note: The incline presented after the therapeutic intervention depicts the transformational nature of these illness conditions.

For the illness conditions classified under the spirit “attack” narrative genre, *aj iloneleb*’ focus on the situations that led to the onset of symptoms and to the risk or protective factors. The medical gaze, therefore, seeks out external agents, intentions or events that provide insight to the agents’ pathogenic intentions. The logic of inquiry is moral and sociological, concerned with the motives, desires and grievances of the individual or family. Common idioms invoked when discussing these conditions include permission, duty, obligation, sin, or proper conduct, which reflect a broad Q’eqchi’ typology of morality. Spirit “attack” is understood primarily to occur to an individual who has broken the normal moral code or transgressed a social obligation, especially concerning the other-than-human realm and the spirits of the Mountains and the Valleys. “It could be when you don’t pray to God for guidance and protection, to ask for permission, that’s your fault to Him,” Francisco said when describing the onset of *eet aj yahel*. “Because of the person’s faults,” Manuel Choc added, “it’s the evil spirit that could get into the person, like the Mountain spirit. It would hit the person and make them go unconscious.”

Throughout the healers’ descriptions of these conditions, the concept of “permission” is common and expressive of the factors leading to or determining the likelihood of an “attack.” The attack of a spirit is seen as a kind of punishment for one’s sins, either by omission (i.e., failing to placate the spirits and request permission), or by commission, (i.e., where an individual wronged another). In either case, the plots of spirit “attacks” all begin and are coloured by an understanding of a moral economy of permission, a core aspect of Q’eqchi’ cosmovision.

Another prominent feature of this narrative genre is the degree to which the onset of the illness symptoms is sudden or rapid. The patient here is described as falling down suddenly, in some cases with clenched teeth, foaming at the mouth, and their eyes rolling in the back of their head. Along with conditions closely related to epilepsy or epileptic seizure disorders, *k’axum xul*

or snake bite is included in this narrative genre because of the similar plot structure and the semantic relation often held by *aj iloneleb*’ between snakes and “evil” spirits.³⁴ Snake bite is clearly a sudden and shocking event that can be conceptualized as an “attack” of some kind. As with the sudden onset of symptoms of snake bite, *eet aj yahel* and *rilom tzuul* are described as occurring in a similar fashion. “When the spirit hits you,” Lorenzo stated, “you go down.” “The spirit hits the person and they go unconscious, they begin to shake and their eyes roll back in their head,” Emilio added regarding *rilom tzuul*. The plot here is characterized by its dramatic nature, and its sudden and disruptive onset. Whether hit by a spirit of the Mountains and Valleys, or bitten by a snake, these spirit “attacks” are instantly debilitating. Thus, the temporal sequencing of events for these conditions is somewhat compressed when compared to the other genres, allowing little time on the part of the healer to treat the condition. These conditions are also more dangerous, and are treated with a certain respect and recognition of their power. It takes a well-trained *aj ilonel* to properly attend to *rilom tzuul* or snake bite.

In Q’eqchi’, *yahel* is a general term that translates as “illness.” The Q’eqchi’ term “*eet*” signifies being irritated or stubborn, or very moody, unfriendly or angry. The phrase *eet aj yahel* is difficult to translate into English, but is commonly understood as “epilepsy” due to the symptoms of falling down, uncontrollable tremors, and an inability to listen to others or interact socially while experiencing the illness episodes. As Manuel Baki articulated, “they scream or they might look back with their neck twisted and their eyes rolling back in the head.” Similarly, Lorenzo Choc observed, “with this condition the teeth are clenched together, and when it starts the person might fall to the ground and be unconscious.”

³⁴ Although in traditional Maya mythology the snake is a positive figure and worshiped as a powerful deity, contemporary healers, largely through various Catholic and Christian influences, have come to associate the serpent with a general notion of “evil” spirit. In some cases, snakes are even described to be the servants of Satan.

Rilom tzuul is described similarly, except it is more severe with a violent characteristic of the “attacks” and greater resistance to treatment. The Q’eqchi’ word “*tzuul*” roughly translates as Mountain spirits. The term “*rilom*” signifies a kind of “seeing.” *Rilom tzuul*, then, translates as the “illness of the mountain spirit”, or, more literally, “the mountain spirit came and looked at the person and they got ill.” Both *rilom tzuul* and *eet aj yahel* likely describe different kinds of seizure activity, perhaps reflecting differences between the symptoms of tonic-clonic seizures and complex partials seen in epilepsy.³⁵

The Q’eqchi’ term *k’axum xul* means snake bite and is placed within this narrative genre due to its relation to the stories, narrative structure, and plots of *eet aj yahel* and *rilom tzuul*. *K’axum xul* phenomenologically manifests the same as the other two conditions and is thus treated with the same degree of care and respect.

The Q’eqchi’ term *sikirk* translates as “numbness,” and reflects a kind of temporary paralysis in the limb or nerves of the individual, as the individual loses mobility or sensitivity in the infected area. As Emilio described, when affected by *sikirk*, “The person cannot walk with his foot and when it’s his hand he cannot get hold of anything. He isn’t happy because he isn’t capable of doing anything. His body part affected would be numb and not work properly.” There are multiple causes recognized for this condition, but one of the most common is the “attack” of a spirit. “To get this type of sickness [*sikirk*] the person is resting in an old house or a place where by the spirit of the devil rests. This spirit will attack the person and get into them,” Francisco explained. Manuel Baki similarly suggested, “It’s the animal that passes through the wind and leaves a bad spirit behind, and when that breeze hits you then you’ll get that sickness

³⁵ Tonic-clonic seizures or grand-mal seizures are those that impact the entire brain. As such, they are the most severe type of seizure and those most commonly associated with epilepsy. Complex partials or simple partial seizures are associated with abnormalities in only one or more areas of the brain. They are less severe than tonic-clonic and sometimes only involve disruptions to one or more sensory perceptions (i.e., hearing, taste or smell).

[*sikirk*], making you numb and not able to move.” *Sikirk* is less severe than the three other conditions grouped within this narrative genre, but is placed here based on the similarity of etiology, narrative structure and treatment approach.

The final stages of the plot for this narrative genre, or “resolution,” center on the extraction of the “spirit” that is attached to or inside the individual due to the “attack.” When the person is “attacked” by one of the spirits, there remains an aspect of the spirit within the individual that causes him or her to remain ill in some instances, or to continue having regular, smaller attacks in others. The “evil” spirit is described as “feeding” on the patient, causing the illness symptoms. This is opposite to the “Fright” narrative genres in which the individual’s spirit is “lost” or frightened out of the body. In these cases, there is an extra spirit within the person continuing to “feed” on them causing serious harm. Thus, the healing drama unfolds around the complex and careful work of extracting the foreign entity out of the body, whether the lingering snake venom from *k’axum xul* or the “evil” spirit from *rilom tzuul*. Extracting the “evil” spirit from within the person usually involves a kind of sacrifice or offering (i.e., *awas*).³⁶ This procedure lures the spirit out of the person and enables *aj iloneleb’* to take it deep into the forest. The extraction of the spirit, therefore, involves making sacrifices and offerings, which are typically various kinds of animals or other food items on which the spirit can feed instead of the patient, a process detailed in Chapter Six.

Once this work is complete, the healer focuses on asking for forgiveness of moral transgressions on behalf of the patient, and that he or she will suffer no more future “attacks.” This aspect of the *awas* healing ritual is similar to the permission ceremonies oftentimes

³⁶ Although the Q’eqchi’ term is the same here, this usage of “*awas*” is not related to *awas* as a condition within the Childhood / neurological disorders genre. *Awas* is used here to refer to a healing procedure where a sacrifice or offering (*toj*) is made to the spirit of the illness that is impacting a person. Chapter Six outlines this process in more detail.

conducted before the collection of plant medicines or hunting in the jungles. These ceremonies, coupled with the extraction of the evil spirit, if done under the proper conditions, will allow the patient to fully heal from his or her condition and return to a pre-condition state. This genre has a similar cyclical plot as observed with “Fright” narratives, where patients return to a pre-illness state.

Nevertheless, a subtle difference can be seen. Due to the strong moral rhetoric invoked with these spirit “attack” conditions, the individual is often brought to reflect on his or her actions and comes to a “new” place once symptoms have subsided. More so than any other narrative genres, these illnesses are understood as a “lesson” from the spirits. They provide a mode of spiritual and existential education and help the individual live in harmony with social and spiritual forces. A kind of “transformational” healing is observed here (Waldram, 2013); the punishment of the “attack” now corrects one’s behaviour and forces the patient to learn from the experience. The plot is in some sense cyclical, but resolves at “new heights” of moral awareness. The patient experiencing snake bite or an “attack” has grown in some existential way, living life more “attuned” to the underlying cultural ethos engendered through their moral visions of the world.

Chapter Conclusions

Going back to Paulo’s case in the opening section of this chapter, it is argued that there are narrative structures to the Q’eqchi’ healers’ understandings of Paulo’s condition. The healers draw upon these familiar plot forms in order to situate Paulo’s illness condition within a broad epistemological structure. During the healing sessions with Paulo, Francisco was guided by the “narrative genres” of Childhood / neurological conditions in order to determine the proper actions to take and what future may result. His familiarity with these narrative genres provided a

loose framework that was imposed on clinical time and within which he interpreted the ongoing succession of Paulo's symptoms and experiences. This is a process of "therapeutic emplotment," which, as Mattingly (1994) outlined, "involves making a configuration in time, creating a whole out of a succession of events." "What we call a story," she continued, "is just this rendering and ordering of an event sequence into parts which belong to a larger temporal whole, one governed by a plot" (p. 812). With their sophisticated narrative genres of mental illness and disorder, Francisco and the other members of the Q'eqchi' Healers Association are quite adept at transforming a random succession of events and symptoms into a story with a coherent temporal ordering, teleological structure, and plot. At times this epistemological structure can aid in the full recovery of their patients. Whereas at other times this is not entirely possible. After three months of treatment during Paulo's case, Francisco decided to end his work due to the severity of Paulo's condition. As a result, Paulo's mom and his family were forced to accept his condition and come to terms with the life he has been given.

Arriving at a similar conclusion while working with physicians in Western medical settings, Montgomery (2006) observed that "Narrative accounts of disease mechanisms or pathological processes are the principle means of organizing symptomatic clues and their interpretive syndromes" (p. 64). While drawing on the descriptive imagery of aesthetic genres Montgomery (2006) further suggested, "Like Victorian turrets beneath a cloud-draped moon, the details of illness, its signs and symptoms, reveal to a clinical audience the kind of situation it is and what is likely to happen next" (p. 64). In a similar way, it is argued that the "narrative genres" recognized by the Q'eqchi' healers have important qualities and characteristics, plots and actors, significant events and props, that signal to them the appropriate narrative and therefore what they are likely to encounter. The early onset and chronic nature of the childhood

conditions, the frightening event, social misfortune or rapid “attack” requiring an exorcist-like intervention, all reflect a broad notion of Q’eqchi’ mental disorders, their “larger developing narrative structures” that healers “actively seek to impose upon clinical time” (Mattingly, 1994, p. 811). Illustrating their overall plot structure, these four “narrative genres” are:

Childhood / neurological disorders. The general structure of this genre involves an inciting incident that occurs before the birth of the individual, usually related to something that the mother or family has done. The main tensions involve questing for answers as the parents seek assistance regarding their child developmental and neurological abnormalities. The temporal aspects of this genre are long and drawn out over the course of childhood and early adolescence and occasionally throughout one’s entire life. The central actors are the parents and family members, with the child and mother having a particularly strong role in the plot development. The resolutions of the plot primarily involve acceptance and/or forgiveness on behalf of those who committed some type of moral infringement before the birth of the individual suffering from the condition. This is facilitated through various ceremonies and healing encounters. The treatment outcomes, however, can widely vary depending on the severity of the condition. The most severe conditions involving brain damage or neurological abnormalities are the most chronic. In this plot, the parents are forced to adapt to the condition and after the initial search for a cure, the family and the individual come to accept, to varying degrees, what has been given to them. In a sense, acceptance is their therapeutic intervention. In the less severe cases, the individual will need constant maintenance throughout his or her life, including periodic visits to healers or spiritual guides, to ensure their inherent susceptibility for these conditions is under their control and does not manifest in a debilitating manner. In the least

severe of these cases, a full “cure” is possible through the intervention of “restorative” based healing. In this plot, the condition is completely gone and the patient’s symptoms entirely abated.

“Fright” illnesses. The fright episode is the pivot around which the plot of this narrative genre unfolds and is the inciting incident or catalyst that propels and shapes the illness narrative. After the “fright” episode, it generally takes between one to three weeks for an individual to become ill. This is because the individual’s soul, that is now trapped at the location where the fright occurred, is outside and away from the person. This separation between the person’s soul and body gradually creates the symptoms or primary tensions associated with this illness condition. The central actors here are primarily environmental “hazards,” such as animals, rivers or lakes, which may happen to cause a frightening experience and where one’s spirit may concurrently be trapped. The therapeutic interventions center on restoring the patient to the pre-illness condition, that is, to “call back the spirit” and thereby eliminate the symptomology of the condition. Although there are variations within this genre, again primarily due to severity, the healers’ narrative overwhelmingly centers on a notion of “cure.” Thus the resolution of this narrative genre is generally clean and simple when compared to the multiple plot endings within the childhood or neurological disorders. The plot structure of the fright conditions is also more cyclical than linear, reflecting a “restorative healing process” where the goal is to return to the state prior to the fright episode.

“Thinking too much.” Within this narrative genre, the cognitive content of thinking too much generally involves or begins with some kind of social misfortune, like problems with a spouse or boyfriend or girlfriend, financial troubles, or the death of a close family or community member. The primary tensions within this genre involve the dealings with a kind of pathological thinking or mood state, a dwelling on the event that ensues, that captures or begins to control

one's patterns of thought. The temporal dimensions of this genre are slower and more gradual compared with fright conditions, often characterized by a slow accumulation of risk factors. The central actors here are the community and family members. The therapeutic interventions within this genre are similar to the "restitution" seen in "Fright" conditions, although they are marked by a longer onset and recovery time. The resolutions here often involve acceptance of one's situation, the changing of one's situation, or the repairing of disrupted social relationships through forgiveness, including relationships to the other-than-human realm. The treatment is known to completely dissipate the illness state if done properly and under the right conditions; however multiple treatment encounters are usually done and symptom relief can take much more time. Thus there is a softer ending to this plot structure, as stabilizing the thinking of the person slowly occurs over several cycles of treatment. In most cases this was seen to be for one or two months as opposed to the weeks mentioned for "fright" conditions. There is, however, an eventual expectation of a "cure," the elimination of the illness condition and a return of the individual to normal day-to-day functioning through "restorative" healing processes.

Spirit "attacks." The inciting incident within this genre is the contact with an "evil" spirit. This occurs by not properly asking permission from the spirits to perform a certain action and is thus seen as a kind of moral reprimand. Because of the severity of these conditions, the primary tension around this plot is the fear of sudden death. The temporal aspect is rapid and sudden, the healer having to act swiftly if the patient is to survive the "attack." The central actors here are the spirits of the Mountains and Valleys, the agents who punish the individual for their wrongdoing. The resolution of the plot is centered on taking out the spirit of the illness, as the attack has left an external spirit trapped within the individual that causes the symptoms. Once the spirit is properly extracted from the individual, the therapeutic outcome expects a return to

normal functioning. However, as a response to the moral reprimand by the spirits the individual has learned from his or her mistakes and has often gained insight or moved to new levels of consciousness or moral growth, a “transformational” kind of healing process.

By analyzing the 17 different illnesses and four “narrative genres” through a narrative lens, other factors emerge that assist with global comparisons among the individual conditions and genres. The analysis of Q’eqchi’ “mental” illnesses and disorders began by distinguishing among the 17 disorders primarily on the basis of four identifying factors (i.e., etiology, symptomology, demographic population, and treatment approach). This analysis facilitated the groupings of each of the 17 mental illnesses within one of the four “narrative genres.” By looking at these genres as “narrative structures” (Mattingly, 1994, p. 811) or “prototypical plot forms” (Good, 1994), additional identifying factors emerge that shed light on and assist with comparisons among the four “narrative genres.” These six narrative identifying factors are: the inciting incidents of the illness episode or how the plot of the condition begins; the major tensions around the complicating factor or disruptions in the plot; the resolutions of the complicating factors; the temporal aspects or how long and drawn out the process of tension and resolution takes; the central actors that are implicated in the onset and treatment of the condition; and the “directedness,” teleology or outcomes of the treatment. Table 9 illustrates broad comparisons among the different narrative genres on the basis of these narrative identifying factors.

Table 9: Comparing narrative genres of Q'eqchi' Mental disorders						
Narrative genre	Inciting incidents	Tensions	Resolutions	Temporal aspects	Central actors	Treatment outcomes
Childhood / neurological conditions	before birth	developmental abnormalities / questing for answers	acceptance / forgiveness	drawn out over childhood and sometimes entire life	children and parents	varies based on severity: no cure, maintenance, cure
"Fright"	frightening episode	loss of one's spirit	calling one's spirit back	relatively quick: two to three weeks for symptoms	animals and rivers	restorative, cure, cyclical
"Thinking too much"	social misfortune	pathological thinking and mood state	acceptance / change of circumstances	slow and gradual	community members	restorative / transitional
Spirit "attack"	contact with "evil" spirits	possible sudden death	taking out the "evil spirit"	rapid and instantly debilitating	"evil" spirits	transformational / moral growth

This analysis suggests that these four “narrative genres” of mental illness and disorder are provisional templates for a story, akin to the broad categories of the comedy or the romance. As Garro and Mattingly (2000) observed, however, “narratives never simply mirror lived experience...Telling a story, enacting one, or listening to one is a constructive process, grounded in a specific cultural setting, interaction, and history” (p. 22). Although containing a prototypical narrative structure, then, the specifics of each plot and illness experience are worked out, filled in, or constructed through the patient and healers’ idiosyncratic interactions. With these four “narrative genres” as provisional templates for the mental illness episode, there is a negotiation in actual clinical time for the unfolding of events. As Mattingly (1994) argued, “The narrative structure of clinical time is not a script...for it is created within the clinical interaction, improvised from the available resources at hand and tailored, quite specifically, to context” (p. 811). Similarly, and as will be observed in later chapters, Q’eqchi’ healing dramas observed during this research are largely improvisational, yet also informed by these broad narrative structures. Stories of “mental” illness and disorder contain aspects of suspense, risk or surprise, not only for the patient but the healer as well.

Overall, there are a few final reflections. First, the Q'eqchi' healers often conceptualize the physiology of “mental” disorders by including other aspects of the human person, for example, the heart, spirit, blood or body. With one exception (i.e., *tib'ljolom*), all “mental disorders” involved these other human aspects in some way. Thus, Q'eqchi' notions of “mental” are broader than physiological undercurrents of disorder within traditional psychiatric categories, a finding often reflected in other Indigenous communities (Waldram, 2004). This being said, however, it is also interesting how several Q'eqchi' conceptions of “mental” disorder relate closely to categories outlined in the DSM. For example, the symptomology and prognosis of *rahil ch'ool* and *xiw xiw* seem to correspond closely with the categories of Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD), respectively. This would support the notion that some illness conditions may occur in “cross-cultural” contexts. Further research in psychological anthropology can investigate these developing results.

This study shows how the Q'eqchi' healers conceptualize “mental disorders” both similar to and distinct from DSM categories within Western psychiatric nosology. Although similarities can be seen between Q'eqchi' “mental” disorders and psychiatric nosology, it is clear that spiritual, cultural and historical notions that are well beyond the purview of contemporary biomedical and psychiatric discourse are also included. How do we make sense of this? Do we dismiss notions of “evil” spirits and witchcraft as merely “beliefs” from a people's distant past, or do we respect and seek to understand how they meaningfully impact the nature and experience of mental illness? As Good (1994) suggested, “although individuals or groups may have mistaken notions about disease, local worlds of medical knowledge cannot simply be judged by the measure of biomedical rationality” (p. 178). Regardless of our epistemological stance toward Q'eqchi' conceptions of “mental” disorders, understanding these perspectives and different

narrative genres adds to the growing literature in cultural psychiatry while also aiding potential dialogues between the QHA members and the Belizean Ministry of Health. Furthermore, by understanding the different mental illness conditions recognized by the Q'eqchi' healers and their narrative genres, as well as the different factors underlying their articulation and narration, PNs and various mental health professionals in Belize may be able to better serve their Q'eqchi' patients and develop higher degrees of cultural competence.

CHAPTER IV: Reading and Emplotment in Q'eqchi' Medicine

One kind of illness, like a sonnet, will be recognizably limited and, however deserving of attention, will take a predictable shape no matter where or when it appears. Another illness more nearly resembles a satiric ode, wildly varied and recognizable only after it is well under way and other possibilities have been discarded. ...In another patient, the physician-reader may discern a fatal diagnosis, a reading that may fix a person's fate as surely (and as dependably) as the oracle in a Greek tragedy (Hunter, 1991, p. 11).

It was still dark when we were awoken by the bare footsteps of Emilio's children scampering around on the hard dirt floor of Emilio's home. Through the cool morning air of the house my hammock began to slowly swing from side to side as one of the children pushed me while running to the next room. The ropes of the hammock rhythmically rubbed on the wood beams above, reminiscent of the steady pulse of a large clock. A rooster from several houses away now joined the children's footsteps. The first streaks of dawn patiently broke the darkness. Life in the Q'eqchi' village of Jalacte slowly arose to greet the day.

Not too long after the sun emerged, Emilio's cell phone rang. Still trying to hold on to the last moments of sleep, he answered with a broken voice. Thomas and Francisco were already up and chatting quietly. Thomas explained that it was a patient calling from the nearby village of San Vicente asking Emilio for his healing assistance. Emilio slowly joined us in the main area of the humble abode while the smell of fresh beans and tortillas saturated our senses. After conversations about Emilio's corn *milpa*, how his crops were progressing and when he expected the first harvest, Emilio's wife and daughters brought us a morning meal. To prepare for its enjoyment, Emilio individually poured water over our hands while the excess gently splashed on the dirt floor below our feet. The day was already hot.

About thirty minutes into our breakfast meal, a Q'eqchi' man named Santos and a young boy, Federico, arrived at Emilio's home. Santos greeted us with a pleasant smile, displaying a cheerful disposition, while Federico's shoulders slouched considerably. He seemed depressed and gave us little eye contact. Emilio's wife and children remained by the cooking hearth in the next room. Francisco, Emilio and Santos chatted for about fifteen minutes, frequently laughing and wiping the accruing sweat from their foreheads. Thomas explained that they were talking about the price of beef and that a villager in San Vicente, the closest village to Jalacte where Santos and Federico lived, just killed a cow and was selling some good meat. Somehow amidst this talk of meat, the conversation shifted to the topic of illness. Santos then told Emilio and Francisco about his son's condition. From what Thomas explained, the father suspects that his son was surprised by an animal several nights ago, was scared by the incident and is now sick, vomiting and excessively worrying; a classic case of *kaanil*, we thought. After listening to the father's story for a short time, Emilio went to prepare for the healing in the next room, where his altar and healing paraphernalia resided next to the warmth of the family hearth. Federico remained motionless. We sat in hammocks and on wooden benches around the edges of Emilio's home until Emilio signalled that he was ready. After Thomas determined that my presence was permitted by Federico and Santos, we accompanied the boy into the next room to observe the healing encounter.

Federico was seated on a large, white, upside-down, plastic bucket (a common chair in Q'eqchi' homes) with his back slightly towards Emilio's ceremonial altar. Emilio's wife and children were on the other side of the room attending to household duties, undisturbed by the healing drama about to unfold. The two brothers, Emilio and Francisco, together began their work. Francisco first attended to their patient, while Emilio continued some preparations by his

altar, ripping, tearing and mixing plant medication while collecting some *copal pom*. To begin, Francisco laid both of his hands on Federico's head and, with eyes closed and with a humble posture, began uttering his barely audible words of prayer. Francisco then moved his hands down and across Federico's body several times while blowing and continuing to mutter his prayers, a healing procedure referred to as *jilok* in Q'eqchi'. This went on for roughly two minutes. Then Emilio, who was still preparing some healing materials by the altar, handed his brother two small pieces of white, waxy *copal pom*. Francisco took the *pom* in his hands and continued his sweeping motions over and across Federico's body. After several repetitions, Francisco placed his hands, each holding a piece of the incense, onto the boy's head. His hands remained there for about another minute and he continued his quiet words of prayer. Federico remained hunched over on the plastic bucket, his eyes open and staring at the dirt floor below his feet. Emilio's wife and children kept to themselves, stealing the occasional glance in our direction. By this time, Emilio finished his preparations and now looked on with interest. After a moment, Emilio placed a small drinking glass of clear liquid on the floor beside Federico's gaze. Francisco dropped the two small lumps of *copal pom* into the glass. One of the balls sank to the bottom of the glass, the other remained near the top. Francisco and Emilio both studied the two copal lumps for a moment and silently continued with their healing work, leaving the *copal pom* in the glass of liquid on the dirt floor.

Francisco then handed things over to his brother, who was already lighting a small fire in an urn situated on the floor just below his wooden altar. The fire began to sizzle and crack as a small lump of *copal pom* ignited in the urn. When black smoke from the fire began to rise, Emilio placed two white candles in the fire and lit them. Federico turned to watch what Emilio was doing behind him. The strong scent of the *copal* slowly filled the room as the fire in the

small urn smouldered. Emilio turned to Federico and rested the two lit candles on his head and, bending over, offered similar words of prayer to those of his brother. After a moment, Emilio crouched down and, in one swift motion, separated the two candles one in each hand and swept them over and down Federico's body. His hands came to rest with one candle on each of the boy's wrists. Emilio's words of prayer continued. This process continued for nearly a minute with one pause for Emilio to blow gently over Federico's body and again wave the candles down and across his head and wrists. Emilio then repositioned himself directly in front of his patient and moved the two lit candles to Federico's feet, placing the candles on the boy's large rubber boots. Emilio's prayers continued for another moment before he moved the candles up to rest on Federico's knees.

Satisfied with this process, Emilio moved the ends of the two lit candles into the fire that still smouldered in the urn beneath the wooden altar, melting the wax to enable him to "stamp" them to the altar where they remained lit for the duration of the healing encounter.

Emilio then placed the small glass containing the two lumps of *copal pom* on his wooden altar while Francisco held the herbal medicine which Emilio had prepared. From a small plastic bowl, Federico consumed a modest amount of the dark green medicinal liquid. The two *aj iloneleb'* then asked Federico to remove his shirt and Francisco poured the medication over Federico's head slowly and carefully. The excess medicine splashed down to the dirt floor and Federico cautiously wiped away the unblended leaves that stuck to his neck and hair. Emilio's children looked on as Francisco passed the empty bowl to his brother. Both healers left the room as the boy pulled his shirt back over his soaked hair.

The healing session was complete and Francisco and Emilio went back to the other room to continue their earlier conversations with Federico's father. We all sat talking for nearly twenty

minutes in the main living area of Emilio's home. Before leaving, Federico's father handed Emilio a sum of money for the treatment. Santos left happy; Federico displayed little change, save his wet head.

Reading a Case in Q'eqchi' Medicine

The previous chapter outlined the narrative structures of Q'eqchi' medical knowledge. It was argued that there are several "narrative genres" of "mental" illness upon which the Q'eqchi' healers draw during their patient interactions and healing encounters. Further, it was suggested that 17 recognizable mental illness conditions, to greater or lesser degrees, fall within one of four general "narrative genres" or cultural resources to which Q'eqchi' healers refer in treating illness episodes. As Good (1994) suggested, narrative templates of this kind function as "possible stories one might reasonably tell about such an illness, potential plots giving order to the events one is experiencing" (p. 146), and "not only report and recount experiences or events... They also project activities and experiences into the future, organizing desires and strategies teleologically (p. 139). The general "narrative genres" of Q'eqchi' mental illness and disorder guide clinical interactions and direct the encounter to some intended future.

This chapter explores the case of Federico's *kaanil*, his fright illness that was briefly described in the opening section. The main purpose here is to determine how the Q'eqchi' healers negotiate the general narrative structures of an illness condition, that is, the "narrative genre" of *kaanil*, with the particulars of a specific case. What kinds of clinical reasoning or cultural logics do the healers employ during this process? How do the healers come to know, recognize, and diagnose a specific illness and how does this inform their treatment approach? To what extent does the patient or their family play a role in determining the plot of a specific mental illness condition? What other diagnostic elements are employed by the Q'eqchi' healers

and how do these relate to or situate a particular illness episode within the generalized narrative genres? How are therapeutic elements based upon or determined by the knowledge generated during diagnostic processes? Do the Q'eqchi' healers simply enact a pre-programmed narrative script for each mental illness condition, or are they attuned to the "emergent" properties of the patient-healer interaction? (Mattingly, 2000).

Based on the analysis of this case of fright illness as well as several other therapeutic encounters, it is argued that *aj iloneleb* operate as "readers" of their patient's "texts," that is, the symptoms and etiological factors involved within the specific cases they encounter. Like the plots that emerge from the well-known genres of the sonnet, the widely varied satiric ode, or the grim bleakness of a gruesome tragedy, the illness conditions recognized by *aj iloneleb* are comprised of several distinct cultural "texts" that the healers are highly adept at "reading" during their therapeutic interactions.

As previously mentioned, the word *aj ilonel* means "seer," "to see," or the "one who sees," as involving the ability to prognosticate disease. There is a logical connection between the acts of "seeing" and "reading" as both involve observation based on previous experience, a kind of apperception, and a vision filtered through conceptual frameworks. More specifically, reading implies an interpretive function or the ability to interpret, in a culturally distinct manner, the diverse "texts" encountered and link them to a broad epistemological framework within which the reading takes on its particular significance. Thus, *aj iloneleb* not only "see" a specific patient, their symptoms and etiological factors, they "read" into them an expected course of events. They also read teleologically, suggesting and organizing possible outcomes and salutary actions. This interpretive act of reading is also, in part, an act of synthesis since readers are also skilled in their ability to integrate the divergent viewpoints or "texts" within a single narrative to

form a comprehensive picture of how the story unfolds and the characters or situations to be conveyed (Good, 1994; Iser, 1978). The reader of a text observes one action or event after another or hears from one character after another while imaginatively entering into the unfolding narrative drama. From this imaginative process the readers come to “know” the story, the central characters, and the genre or plot.

The plot or genre of a particular illness condition is “known” to *aj iloneleb*’ through different modes of apperception understood analogously as available “texts” to be read during therapeutic encounters. The term “text” here is understood as anything containing a coherent set of symbols that can be interpreted by *aj iloneleb*’, and which signifies or helps to construct the plot of a particular case. As Staiano, (1981) argued during her work with various Indigenous communities in southern Belize, “the illness episode and its concomitant set of interpretations and actions can be read as a ‘cultural text,’ as a series of signs connected in a particular syntactic arrangement” (p. 329). Further, “it is these syntactic and semantic components of the illness episode,” that “become a text with embedded cultural meanings” (Staiano 1981, p. 329). In this research, the view of “text” follows Staiano’s remarks while remaining close to its original meaning as “textum” or “textile.” Therefore, “text” necessarily implies the weaving together of multiple symbols or different diagnostic elements that, through a synthetic process of clinical reasoning, signify to *aj iloneleb*’ the story being enacted and the therapeutic elements required. Dialogues with the patient’s blood, divination of *copal pom*, bodily sensations, reading of the ceremonial fire, and the narrative accounts of experience from the patients or their families are some of the many “texts” that are “read” and interpreted by *aj iloneleb*’ during their healing encounters. These texts signify for *aj iloneleb*’ where a particular case is located within an epistemology of “narrative genres.”

It is by understanding how *aj iloneleb*’ “read” various “texts” during therapeutic encounters that their process of clinical reasoning is uncovered. Like lawyers, moral reasoners and detectives, physicians and, it is argued, *aj iloneleb*’, must negotiate the “fit” between the organizing principles of their professional ethos and worldview with the specific problematic circumstances at hand. They do so through a reasoning process that moves dialectically between their knowledge of “narrative genres” and the reading of specific “texts.” In each of these professional worlds—from law or medicine, to morality or criminology—the set of circumstances where general principles meet particular situations is referred to as a “case.” Reading a case in Q’eqchi’ medicine thus involves what Montgomery (2006) referred to as a kind of “narrative rationality” where “reasoners start from a particular phenomenon and, using preliminary evidence, hypothesize its possible causes; those hypotheses are tested against details revealed by closer examination” (p. 47). The process of *aj iloneleb*’ reading a particular text thus involves a similar kind of circular, hermeneutical-interpretive procedure that moves between the cultural logics underlying their cosmovision, the abstract generalities of different “narrative genres,” and the “texts” or particular signs and symptoms of a single case.

Reading a “case,” in both Western biomedical practice and Q’eqchi’ healing, is an intuitive and interpretive process that relies on the ultimate casuistry of narrative. As Hunter (1991) described regarding physicians in Western contexts,

Physicians begin by hearing the story of the illness and then “read” the body, interpreting, sorting, matching all the while. As expert readers they use both scientific knowledge and a familiarity with the plots of similar cases to make sense of a welter of detail, sorting through a differential diagnosis, testing hypothetical accounts of disease against the details of this particular one. The diagnosis that emerges is the physician’s interpretation of the

events and signs of illness, and it places the patient in the midst of a recognizable story of disease. Narrative thus bridges the gap between rule and case (p. 46).

A similar processes is observed in the work of the Q'eqchi' healers wherein the reading of a specific case occurs on the basis of a general taxonomy of familiar illness narrative genres. As such, the healers have become, through years of experience and embodied knowledge regarding their profession, expert readers of specific cases.³⁷ They are able to identify the plot of a condition in a relatively short span of time and prescribe a treatment and intended future course of events. Like general practitioners, Q'eqchi' healers are masters of their craft because of their familiarity with a wide range of medical cases, knowledge of different “narrative genres” and cultural traditions from which they derive, and the ability to select the most appropriate working principles for a particular case.

Unlike medical practitioners operating within “Western” biomedical frameworks, however, Q'eqchi' *aj iloneleb'* draw on “texts” that are beyond the materialistic restrictions of biomedical epistemological frameworks. In biomedical practice the reading of a “text” occurs primarily through a materialist lens wherein sickness is approached through bodily and behavioural clues that permit the physician to “read into” the sick body and identify or intervene against pathogens and pathophysiological processes. The “texts” here often remain within the purview of the patient or family story, the symptoms, diagnostic images, blood tests and other physiological examinations, in an attempt to get at the underlying story. The extraction and sampling of cells or tissues for the presence of disease in the “biopsy” is a potent example. These different “texts” inform a clinician's reading of a specific case and locate that case within a general taxonomy of similar cases. With regard to mental illness, a psychiatrist or Psychiatric Nurse Practitioner working in Belize uses similar processes; they draw on personality tests,

³⁷ “Embodied knowledge” is described in more detail in Chapter Five.

surveys and questionnaires that combine with the patient's narrative to diagnose a specific case within a broad taxonomy of possible cases, that is, the DSM. What constitutes a medical "text" is largely determined by an epistemological and ontological framework, which, in biomedicine, is a Cartesian-Newtonian worldview and materialist assumptions that produce the recognizable "biological gaze" of Western medicine (Medina, 2006; Nigh, 2002).

As witnessed among the Q'eqchi' healers, however, their "reading" of the patient moves away from, rather than into, the body and material events. Indeed, as Good (1994) observed, "diagnosticians in many societies seldom inquire about symptoms, and the sufferer is often not even present when diagnostic inquiries are made. Instead, the social field or the spiritual world is often the subject of "diagnostic" inquiry" (p. 23). Like Good's observations, the Q'eqchi' *aj iloneleb'* frequently ignore the patient and their body. Rather, the medical gaze of Q'eqchi' *aj iloneleb'* oftentimes involves external agents, intentions, relationships and events that provide prescriptive clues into the patient's pathogenic situation (Harvey, 2008). This is a process described by Nash (1967) in her work with highland Maya as a form of "sociopsy," that is, a detailed evaluation of the quality and tone of the patient's social and spiritual relations. Through the interpretive lens of their cosmovision, the logic of inquiry—and thus the "reading" of their patient's story—is largely sociological, cosmological and spiritual. It is concerned with motives, desires, relationships with the Mountains and Valleys, moralized actions, the economics of permission, a moral causal ontology, and the cosmological forces that impact the development of a person's destiny, or *maatan*. The hermeneutical process of "reading" is similar between the Q'eqchi' healers and Western physicians, and both are empirically trained to provide a rational narrative of the specific cases they observe. However, the difference is in the variety of "texts"

upon which they draw and their interpretive and cultural logics that inform the “reading” of a single case. Thus, the creation of distinct narrative genres of illness ensues.

To begin, the “contexts” of risk factors associated with Federico’s fright illness are explored. That is, the reading of medical texts and circumstances that, according to Francisco and Emilio, led him to his illness state. Following this, the logics of *aj iloneleb*’ clinical reasoning and their diagnostic processes are examined; that is, how they “know” what condition Federico is suffering from and how the process of “reading” different “texts” helps determine the treatment approach. Finally, the therapeutic elements of this clinical encounter are highlighted, suggesting that Francisco and Emilio, in some sense, insert new restorative “texts” into the illness narrative from a common understanding of “fright” narrative genres and help to alleviate Federico’s symptoms.

The “Contexts” of Risk and Protection

Through later interviews, Emilio recalled Santos’s original explanation of his son’s condition:

He [Federico] was walking on the road. He went to leave a sister at school in the morning, since they live far away. He came very early about 4:00 am to leave his sister on the bus. His sister told him that she would take the flashlight since she might reach back late from school. So he returned back to his home that morning without a flashlight. On the way he met a possum. He was going through the trails and wasn’t expecting for anything to happen. He got scared when he met the possum on the way back. The possum hit him on his foot. That was why he got scared. When he began to develop the condition, he began to get tired, his stomach growled. He now has diarrhea and headaches. He tried medications from the hospitals [injections and pills], but nothing helped him. He later remembered that

something happened to him on the way. That is why he called me [Emilio]. Everybody knows that with this fright sickness you'll have to smoke the patient and call the spirit. We took care of this young boy today, called back the spirit and smoked him. That is what we did for the young boy.

This story outlines a number of salient features relevant to the medical narrative, the most important of which is the disruptive incident of fright. The family first sought treatment at the medical outpost in Jalacte, receiving several Tylenol pills to aid Federico's growing headache, a typical treatment hierarchy of resort among Q'eqchi' communities (Staiano, 1981). This was to no avail, however. After consultations with the family, Federico and his father suspected it was a case of *kaanil* that could only be remedied by a local Q'eqchi' healer.³⁸

Q'eqchi' healers and community members generally understand that a person's spirit is trapped in the area or by the situation that caused the frightening incident. In this case, Federico's spirit was trapped by the animal that caused the fright. As a result, healing naturally involves a "calling back of the spirit" to the person, the first step toward restoration. When the family agreed that Federico might be suffering from a case of *kaanil*, Emilio was contacted and Federico and Santos arrived to seek his assistance early that morning.

Before going deeper into the cultural logics employed by Emilio and Francisco regarding this case, it is important to determine why this happened to Federico at this time. What is it, according to Francisco and Emilio, that led Federico to interact with the creature that morning and become frightened? Would anyone have become frightened that same morning, or was this something particular to Federico, to his disposition or personality? Exploring answers to these

³⁸ It is interesting to note how Emilio says "everybody knows" that with fright sickness there are certain things only a traditional healer can perform (i.e., the "smoking" and "calling back the spirit"). This reflects a cultural common sense regarding this fright condition and suggests how the "narrative genres" known to the Q'eqchi' healers also pervade the broader knowledge of Q'eqchi' community members.

questions allows a narration of Q'eqchi' conceptions of "risk" and "protection" to unfold and offers a glimpse into the "contextual" information that informs the reading of a particular case.

During interviews later that day, after the healing encounter with Federico in Emilio's home, Francisco and Emilio outlined several factors that they suspect contributed to Federico's condition. When asked if there was anything that Federico could have done to protect himself from being frightened by that animal, Francisco replied,

If the boy [Federico] would have been strong [*kaw*] enough to withstand the fright he could have killed the animal. He didn't have any stick or machete, absolutely nothing with him so in that case he felt vulnerable, and he got frightened [*kaani*]. I've experienced it as well. I went to give away the sacrifice [*toj*] and those animals came to me. I kicked them and I never got scared [*xiwajenak*]. It would have been the same with him [Federico] but he just got scared. Like I always say, once the person has courage [*xkawil xch'ool*] everywhere he goes and meets anything he won't get frightened, but the one who doesn't have courage as he sees, hears or meets anything on the way he will get frightened. If a person who is weak [*yaj*] sees, hears, or meets anything he would get frightened easily, but the one that has courage he won't get frightened easily.

Several times during interviews with *aj iloneleb'*, the concept of "weakness" is mentioned as an important risk factor in the narration of an illness episode. In this excerpt, Francisco juxtaposes a general kind of "weakness" with a kind of "courage" suggesting that, had Federico displayed "courage" during that incident of fright, he likely would have not become afraid, "lost" his spirit, and subsequently become ill. In this way, courage and strength become important protective factors against fright illnesses of this type.

In Q'eqchi' parlance, strength and health are synonymous. The root “*kaw*” means strong or healthy and *kawilal* means a person who is healthy or who displays strength. Likewise, the general root term for weakness is “*yaj*” which is also used for the general concept of illness, and *yajel* for the individual who is ill or weak. The term “courage” as used here by the translators comes from the Q'eqchi' word *xkawil xch'ool*, meaning “the person who has a strong soul or spirit”—“*kaw*” again being the main root. This term, *xkawil xch'ool*, can also mean a person who is successful in life or someone who is able to overcome challenges, strength being the moderating concept. Thus, what often pervades Q'eqchi' illness narratives, especially those expressed by *aj iloneleb'*, is a tension between “*yaj*” and “*kaw*,” between weakness and strength. This tension is related to “risk” and “protective” factors that surround an illness episode, where “risk,” like “weakness,” is that which makes one more likely to develop an illness condition, and “protection,” like “strength,” makes one less likely. Part of the capacity of *aj iloneleb'* is to identify or read a “weakness” or “risk” within the “text” of their patient's symptomology, cosmology, or life history. Once the condition is located within a broad epistemological and cosmological framework, the Q'eqchi' healers are able, if required, to articulate the factors contributing to an illness state and, through their healing work, construct empowering social spaces where “strength” and “health” can emerge.

In a way, the strength and weakness of a person in Q'eqchi' discourse is not dissimilar from the strength (i.e., protective factors) and weakness (i.e., risks) of the immune system in Western biomedical contexts. This is a language with which we are familiar. The stronger one is, the more potential or probability one has in combating a threatening illness caused by viruses or bacteria. The weaker one is, perhaps as a result of stress, poor diet, or simply general fatigue, the more likely one is to develop an illness. The same is true for a mental illness: the greater strength

we have, the more likely we are to combat the threat of a generalized anxiety or major depression. Yet, in the Q'eqchi' "reading" and interpreting of a medical condition, it is not so much the inner state or physiological condition that becomes the "text" to be "read" and observed by *aj iloneleb'*. Rather, the healers' gaze is drawn to the external aspects of a particular case. In Q'eqchi' contexts, "strength" is largely determined by one's day of birth, their *maatan*, or the gifts and offerings left to the spiritual worlds during their life and thus their moral relationships to the other-than-human realm (i.e., the Spirits of the Mountains and Valleys and *Qaawa'*, the creator). All of this highlights the important notion that the "texts" available and the "reading" of medical reality for Q'eqchi' *aj iloneleb'*, although logical and empirical, are saturated by and filtered through their perspectives of cosmovision.

Delving deeper into the cultural logics of strength and weakness, a further interview with Francisco elucidated why some people are more prone to weakness and others to strength, some to health and others to illness. Regarding Federico's condition Francisco explained,

It all depends on your day of birth. All of us have a different day and mine was a good day. I don't worry if somebody comes with machete or gun after me. I won't get frightened [*kaanil*]. But with the boy [Federico], it might be different. Like I tell you the other day, if a person is born on one *Aj* or two *Aj*,³⁹ he would easily get *kaanil* and the one that is born on ten or twelve *Kawoq*, they won't get frightened easily. If the person is born on a good day or a strong day, if he has a good destiny/gift [*maatan*] he would be strong [*kaw*]. I was born on six *Iq'* so I'm not afraid, and even if I drop off a cliff I won't get frightened. The ones that are born on one *Ix* or two *Ix*, they are weak [*yaj*] and as he sees or hears something they would easily get sick. Those are the complicated ones in life. If the person

³⁹ Here Francisco is making reference to specific days in the Maya calendar. See Chapter Two for more details.

[Federico] wasn't weak then the animal could've passed and he wouldn't get sick. If the spirit is weak in that case, anything that happens he would get sick right away.

As explored in Chapter Two regarding the concept of *maatan*, the Q'eqchi' healers understand that the day on which someone is born carries with it certain powers. These "days" signify a force, "gift," or "destiny" that humans "carry" with them from the time they are born. They are self-evident and empirically observable in an individual's tone, aesthetic styles, character or quality of life. In another sense, *maatan* can also be understood as a Q'eqchi' theory of personality, that helps in understanding why people in a community possess different traits and dispositions, talents and preferences. It is a "theory of the person" firmly grounded in a worldview and ethos where spirituality or the cosmos is the key referent.

In this excerpt regarding Federico's ill state of fright, Francisco draws upon the interpretive logics of *maatan* to conceptualize why it is that Federico may be susceptible to *kaanil*, or why he was not strong enough to fight it off. "If a person is born on a good day, or a strong day," Francisco suggested, "They will be strong." If they are born on a weak day, "they are weak" and become the "complicated ones in life." Emilio also explained that Federico was born on one *Ix*, a day prone to weakness and fright conditions. Simply put, Federico is weak; this weakness led him to become afraid of that animal, "lose" his spirit, and become ill. Federico's character, defined by the day on which he was born, is a risk factor and that aptly explains his susceptibility to frightening situations.

There are a host of narrated events that come to bear on any particular clinical encounter. These aspects inform and accompany the reading of specific "texts" available to the Q'eqchi' healers and can be understood as the "contexts" of the therapeutic case. The "contexts" here are those cultural elements which accompany the reading of the texts and specific case. This notion

of what accompanies the “text” in a clinical encounter goes beyond what is said or even what may occur in subtle, non-verbal signs in the environment in which a text unfolds (Ricoeur, 1980). The cultural “contexts” of a medical encounter are not simply material objects or structural arrangements, such as the altar in the room or heat of the family hearth. The contexts in this case are what *aj iloneleb*’ bring into their reading of the different texts available to them. On this basis, “reading” a “text” is made intelligible, logical and readable. The dialectic of weakness and strength, of risk and protective factors, and the positioning of the patient’s *maatan*, form a background theory within and upon which the texts and narrative accounts of experience are read and logically unfold. As recounted by *aj iloneleb*’, Federico’s narrative is contextualized by the concept of “*kaw*,” a weakness that has been with him since birth and a disposition making him susceptible to the frightening situation he experienced.

Emplotment and the “texts” of Q’eqchi’ Diagnosis

In light of the foregoing, there are many different kinds of “texts” recognizable within Q’eqchi’ medicine that *aj iloneleb*’ “read” during therapeutic encounters. These texts guide them to a diagnosis, identify the appropriate narrative, and determine what they should most appropriately do during the treatment regimen. *Aj iloneleb*’ have become expert readers, able to see and locate specific signs within a particular illness narrative that guides their therapeutic encounters. Q’eqchi’ healers “read” the texts available to them during therapeutic encounters that are informed by or based on their understanding of “narrative genres” of similar conditions and the contexts of their cosmovision. This is a process of therapeutic emplotment.

Operating from Indigenous epistemologies and ontological assumptions, the Q’eqchi’ healers have developed, over the course of their healing work, “texts” entirely distinct from biomedical science. These texts are, for *aj iloneleb*’, guides and companions in their healing

work. They are modes of diagnostic apperception that inform the narrative enfolding of events within each specific case. Two of these “texts” are discussed in this section: the reading of the patient’s blood; and the divination of *copal pom*. The cultural logics and clinical reasoning underlying their operation are explored.

Reading the blood. In Emilio’s kitchen area, Federico was seated on a large upside-down white plastic bucket, his back was to Emilio’s altar and he faced the warmth of the family hearth. Emilio’s wife and three of their children went on with their morning work paying little attention to the activities of their father and uncle. While Emilio prepared the herbal medication needed for Federico’s treatment, Francisco prayed and was attentive to his patient’s wrists, feeling the blood move through Federico’s veins, listening for the quiet presence of illness.

Reading the “pulsing” of their patients’ blood while offering words of prayer is arguably the most ubiquitous aspect of Q’eqchi’ *aj iloneleb*’ medical practice and a quintessential aspect of their clinical reasoning and diagnostic processes. Every healing encounter observed during the nine-month project in Belize involved, to some degree, “pulsing” coupled with prayer.

Previous research with Maya communities around Central America and the Yucatan peninsula also attests to the important work of pulsing in Maya therapeutic encounters (Balick, De Gezelle, & Arvigo, 2008; Chevalier & Sanchez-Bain, 2003; Fabrega & Silver, 1973; Groark, 2008; Kahn, 2006; Molesky-Poz, 2006; Tedlock, 1982; Vogt, 1969; Waldram, Cal, & Maquin, 2009). Perhaps the most detailed data on pulsing in Maya communities comes from Chiapas, Mexico. In the Tzotzil community of Zinacantan, Vogt (1969) reported that the “healer feels the pulse of a patient inside the elbow, at the wrists and on the forehead,” and that “the blood ‘talks’ and provides messages” which the healer can in turn understand and interpret (p. 422). Based on research several years later in this same community, Fabrega and Silver (1973) also observed

that “the blood not only tells the *h'ilol* [healer] the sources of illness, but also how many candles are wanted, what mountains and shrines must be visited, and so on” (p. 151).

Pulsing, as a therapeutic and diagnostic process, can also be found in the traditional systems of medicine in various cultures throughout the world, as well as in biomedicine, although in a somewhat different form. Feeling the pulse is still a widely used contemporary diagnostic tool, most well known in Traditional Chinese Medicine (TCM) and Ayurveda (Ross, 2012). The current work with the Q'eqchi' healers adds to the research in this area. Through the work with Q'eqchi' *aj iloneleb'*, it is argued that reading the pulse is part of a clinical reasoning based on a narrative structure of illness, and the “reading” of a patient's pulse becomes a diagnostic “text.” Through a synthetic process, this “text” weaves together with other diagnostic information to “emplot” or locate the case at hand within an epistemological framework of similar cases (Mattingly, 1994).

In an interview following the healing encounter with Federico, Francisco and Emilio described what they feel in the blood and the information received during this process. “For *kaanil* it's like when you are frightened, you would shake/jump when frightened and so the blood would be like that also, would jump in the veins.” “We are taught,” Francisco continued, “that if you feel the pulse as to what sickness it is, like *kaanil* in this case, the person's blood is fast and will jump because they are afraid.” Emilio added in a later interview that Federico's “pulse was shaking and that is the way we determined that he was suffering from *kaanil*.” Emilio continued,

The father told me. I asked him what his son was suffering from, how he felt. So he directly told me that on the road he met something. He said that he thinks that was what was wrong. When we started to heal him, we determined that it was *kaanil*. For *kaanil* the blood is jumping fast like it wants to go somewhere. It is frightened. It is shaking. It is

not like when we are normal. When we are normal our pulse would have a slow steady beat. This one, it is frightened. That was how we determined it to be *kaanil*.

In Q'eqchi' medicine, the movement of the patient's blood provides important information that guides the therapeutic encounter. Reading and recognizing the frightened movement within Federico's blood signals and confirms for *aj iloneleb'* that it is indeed a case of *kaanil* and locates this particular case within their familiarity of "narrative genres." The story told to Emilio and Francisco by Federico's father is corroborated against the reading and interpreting of the patient's blood.

In another descriptive passage, Francisco further explained the connection between Q'eqchi' healing prayers and their reading of the pulse:

A normal person's blood would flow good, but if someone has a sickness, when you feel the pulse it has a difference in feeling. In the prayer you'll ask the blood to talk to you openly so as when you touch it you will feel what the sickness is. When you touch the pulse, you will ask how it took place and you'll mention different conditions. If it responds then you'll know it that way. If it's *kaanil* the blood will be moving fast, it will be frightened.

As opposed to analyses in previous research (Balik, DeGezelle, & Arvigo, 2008), the Q'eqchi' healers' work of "reading" into the pulse is not simply an ability to recognize a number of different types of pulses that may occur in response to different illness conditions. What actually happens in the "reading" of the pulse is subtly more sophisticated. What Francisco described here, and what several other healers also mentioned during other ethnographic interviews, is that their ability to "read" a pulse is not a one-way activity. Rather, it is inherently dialogical: it involves "speaking" and "listening," and is reminiscent of an actual "conversation" or "dialogue"

with the blood itself. “In the prayer you’ll ask the blood to talk to you openly,” Francisco explained, and “the blood will tell you what condition it is.”

Built into the structure of the main Q’eqchi’ prayer said at the beginning of all healing encounters—a prayer referred to as “*remer*” or “*remerik*” in Q’eqchi’—is an actual probing of different illness conditions. This important prayer is also referred to as *ch’e’ok kik’* in Q’eqchi’, or “feeling the blood.” When *aj iloneleb’* utter this prayer at the beginning of their healing encounters they are listing each known condition by name, while asking the blood to respond when the correct condition is named. This is not a random listing. Based on information gathered and apparent signs and symptoms, they work from most to least probable. As the Q’eqchi’ healers pray and attend to the movement of the blood in the veins, they are waiting and expecting the pulse to “jump” or “shake” when the correct condition is named. Thus, it is not so much a repertoire of recognizable pulses that the healers have developed and use for their diagnostic process and clinical reasoning as some research may lead us to believe (Balick, De Gezelle, & Arvigo, 2008). Rather, it is an ability to effectively have a “conversation” with the blood. The healers ask the blood to respond when the correct condition is named during the prayer, and they are able to read “the answer.”

Aj iloneleb’ begin by hearing the story of the illness and then “read” the textual data contained within the blood while interpreting and sorting the relevant information. The dialogue with the blood, like that with the patient and family, situates the current case within their “narrative genres” of similar cases, thereby organizing therapeutic strategies teleologically. The blood, then, is a “text” to be consulted and a guide for the healers’ process of fitting the narrative structure with the specific circumstances at hand. Like other important “texts” in Q’eqchi’ medicine, the blood plays a key role in shaping “therapeutic emplotment” (Mattingly, 1994). In

the quiet murmur of Francisco's prayers while gently "reading" his patient's pulse, Federico's blood subtly "jumps" and "shakes," suggesting and confirming for Francisco the location or plot of the current case within a framework of similar stories: a case of *kaanil*.

These perspectives reflect Tedlock's (1982) and others' observations in the Tzeltal community of Oxchuc that pulsing is a dialogical process where the healer "questions the patient and his relatives—his spouse, parents, and children—naming persons with whom he may have had a quarrel. While he does this, he waits for the blood to "talk," for the pulse to leap when he names the person responsible" (p. 135-136). Similarly, Nash (1967) observed that "pulsing is not simply a monologue by the patient but rather a dialogue in which the curer's pulse from his thumb pressed on the patient's [thumb and] speaks to the patient and causes him to reveal his fears" (p. 133). Thus, in *aj iloneleb*' descriptions, as in Tedlock (1982) and Nash (1967), the speaking, listening and reading of the blood involve a combination of Turner's (1975) "divination" and "revelation" processes. Turner suggested that divination is by nature analytical and dualistic, a taxonomic system that "seeks to uncover the private malignity that is infecting the public body" (p. 15). Revelation, on the other hand, is holistic and nondualistic, using connected sets of "authoritative images and root metaphors" to assert "the fundamental health of society grasped integrally" (p. 15-16). In these Q'eqchi' examples, it would seem that the "reading" of the blood involves a combination of Turner's divination and revelation, carrying out the analytic unmasking of the patient's private malignity within the larger context of their narrative genres and cosmovision.

It is important to note here that through this spiritual process of communication, the blood is animated with an ability to "talk" to the healer. For many Maya communities, including the Q'eqchi' in southern Belize, the blood is understood to be the physical and tangible location

of the person's spirit. Rojas (1947), for example, suggested that the Tzeltal "curer talks with the spirit of the patient by talking to the pulse" (p. 584). Holland (1962) also found that "the pulse is the tangible, material expression of the human spirit" and that "the contemporary Tzotzil maintain the ancient Mesoamerican belief that the blood is the substance of the person" (p. 27). Hence, to view pulsing as simply passive "reading" would entirely miss the essence of this procedure. It is a dialogical process involving a recognized agency on both sides of the communication. The Q'eqchi' healers "speak" with the blood in a manner reminiscent of the biomedical practitioner speaking with the patient, to determine both the nature of the illness and the effectiveness of treatment. The pulse will "tell" the healer (i.e., react) when the treatment is being effective. Pulsing, in a way, disconnects the patient from the therapeutic process, and although the healers gaze appears to be focused into the patients' body, the nature of this "reading" process is distinct from previous conceptions of pulsing thereby more closely resembling a kind of "sociopsy" (Nash, 1967).

Reading the *copal pom*. After reading Federico's pulse at his wrists, feet and forehead, while offering prayers, Francisco focused his attention on the *copal pom*. Among contemporary Q'eqchi' Maya communities, *copal pom* is often used in ritual settings, healing or religious contexts, *mayejak*, or other Maya ceremonial fires. *Copal* is a white, waxy, resinous substance derived from the sap of trees at intermediate stages of polymerization and hardening, not quite as hard as amber. Today, it can be purchased relatively inexpensively in local shops around major centers in Belize and Guatemala. The word "*copal*" in Q'eqchi' derives from the Nahuatl Aztec language and means "incense." The Q'eqchi' word "*pom*" is used to describe that which is to be burnt in the ceremonial fire, or that "activity" that is in harmony with the fire (Molesky-Poz, 2006). For the Q'eqchi' healers, *copal pom* is a highly prized aesthetic aspect of their healing

encounters. When burned, it fills the air with its characteristic black smoke and powerful scent. In addition to prayer and pulsing, burning *copal pom* is, for the Q'eqchi' healers we worked with, a ubiquitous aspect of their healing practice. When making offerings or a *toj* (i.e., payment), or when someone is attempting to placate or offer thanks to *Qaawa'* and the spirits of the Mountains and Valleys, *copal pom* is often the first among many offerings to be burned in the ceremonial fire. In this way, it has important “economic” value mainly for its spiritual and cosmological significance. “With *pom* you communicate with the spirits,” Francisco frequently suggested.

In the healing encounter with Federico, however, *copal pom* is not only used as incense, but also for divination. In this way, the *copal pom* becomes an important “text” that, when correctly read, can determine the narrative course of a patient’s condition or the “directedness” and teleology that transpires (Good, 1994; Ricoeur, 1981). In other words, the “reading” of *copal pom* during Federico’s therapeutic encounter is, in addition to the reading of the blood or pulse, another means of “therapeutic emplotment” (Mattingly, 1994).

During an interview with Francisco shortly after his healing session with Federico, he explained the use of the *copal pom* and why it was placed in the water after it was moved over and across Federico’s body:

As you throw the *copal* in the glass of water you will watch to see if it goes right to the bottom. Then you throw the second one and watch also. By watching the *copal* it’s showing that it’s true that it’s *kaanil*. As you throw it in the glass of water, if it would float then he [Federico] doesn’t have *kaanil*. When the *copal* sinks to the bottom it means that they have *kaanil*. If a person has *kaanil*, if you throw a *copal pom* in water and goes

directly down. If it's not *kaanil*, it floats. If a patient is weak the *copal pom* will sink but if the patient is strong it will float.

In another passage Francisco related,

The *copal* will change because you'll say the prayer, where the boy [Federico] got frightened and you'll ask the spirit if he really got frightened. By talking to the spirit the *copal* will show you if it is *kaanil*. We say the prayer asking if the patient got frightened; when one come up and one go down it will determine if the person will get better and if they have *kaanil*. In this case one gone down and one stayed up and so the boy has *kaanil*.

By moving the *copal pom* over his patient's body, Francisco is "talking to the spirit." During this "conversation" with Federico's spirit, it is said that the *copal pom* receives an imprint regarding the underlying condition of the patient's spirit. Interestingly, if one of the lumps of *copal pom* sinks and one floats, this confirms, for the *aj iloneleb'*, that it is a case of *kaanil*, although the polarization suggests a less severe diagnosis. The scenarios described are understood as different "texts" that impact the interpretation of the specific case and contribute to the overall development of the therapeutic plot.

In a separate interview, Emilio further explained this process:

The *pom* submerged would be the spirit that would be lost. It depends on which of the *pom* that would be submerged, from there you can tell which of them it would be. It could be the foot, the hands either left or right, or the head. That is why we would have the five *pom* put in water [in some cases]. That is why we are trained to see where the person is having *kaanil*. This one [Federico's case] is with two *pom* for hands and feet. When one submerged in the water, it means that one spirit is lost or not complete in the

person. It is the way we know that the person is sick. If one stays on top, then the person would not be seriously ill. The person would be sick and would be in bed. If two were submerged, he would be really sick then. You would need to do *awas* [toj] then. If it is only one submerged, only one spirit is loss. He would not want to eat, he would not want to sleep or he would be restless. He is afraid. In that way, we know what is wrong with the individual. What we knew was that the boy indeed had the *kaanil*. His spirit is gone.

One of his spirits is not there. He got scared. That is why we would use the *pom*.

According to Emilio, then, the Q'eqchi' concept of personhood defines five different spirits associated with the body: two for the feet, two for the hands, and one for the head. A case of fright illness can result in different degrees based on which of the five spirits, or how many in total, were "lost" during the incident of fright. Explaining these five spirits in more detail, Emilio related:

It is the corners of the person. That is what we would call upon, either on the hands, feet or head. Our head thinks, our hands work, our feet for walking or passing through. That is what we would be calling upon in the prayers. All healers would be using the five spirits. When one of your spirits is missing, you get tired and sick. The spirit is like the shadow, it goes wherever you go. It must be with a person.

In Federico's case, Emilio suggested that only one of his spirits was lost, that of his foot where the animal had hit him on the path early one morning. As a result, this spirit of Federico's is now with the animal or still at the site where the fright incident occurred. While praying and performing the *jilok* with the *copal pom* in his hands, Francisco reads Federico's spiritual condition and asks the spirit to attach to or leave a mark on the *copal pom*. "The *pom* attracts the spirit," Emilio explained, "It is the sap of a tree and it is in the prayer as well that it [Federico's

spirit] should come into the *pom*.” By reading the “text” of the *copal pom*, Emilio and Francisco observed that only one of Federico’s spirits was “lost,” thereby situating this case as a mild occurrence of fright not requiring serious medical intervention.

Overall, the analysis of these different medical “texts” highlights the cultural work of clinical judgement and diagnosis. The “reading” of the *copal pom* and the blood pulse are diagnostic processes understood as a “therapeutic emplotment” that help to “enfold” this particular case of fright illness within “larger developing narrative structures” or “narrative genres” (Mattingly, 1994, p. 811). These texts function for *aj iloneleb*’ as modes of diagnostic apperception within each therapeutic case. As expert readers, Q’eqchi’ healers draw on their familiarity of the plots of similar cases as well as the dialogical knowledge that “emerges” during diagnostic practices to make sense of a welter of detail, testing hypothetical accounts of disease against the details of this particular one (Hunter, 1991; Mattingly, 2000). The appearance of the *copal pom* and the pulsing of the blood are “read” to locate the specific case within a narrative epistemology. Dialogically circling between the available clues inferred from the reading of specific “texts” and the general rules that underlie their “narrative genres” of mental illness, *aj iloneleb*’ create a plausible and rational diagnosis and, thus, a treatment regimen. Like those of Western medicine, processes of clinical judgement in Q’eqchi’ medicine, operate within a hermeneutic circle, that process of narratively and dialogically reasoning from part to whole to part again (Hunter, 1991). In narrative terms, then, Q’eqchi’ diagnosis is primarily the ability to discern plot through the dialogue between and “reading” among specific “texts” and the general taxonomy of illness narrative genres.

The “texts” of Q’eqchi’ Healing

During observations of Federico’s healing episode, there were several therapeutic aspects that emerged. These include: the healing prayers, incense and burning of *copal pom* and candles, and the herbal medications. These elements are conceptualized here as different healing “texts” that the healers strategically insert into the medical plot to alter the illness narrative in some way. As distinct from the “texts” of diagnosis, these healing “texts” seek to move the patient to a desired future; they contain a vector or “force” and are, therefore, principally about teleology or directedness. In this way, healing becomes the work of weaving new “texts” into the already unfolding drama in order to alter the illness narrative and further the plot to some agreeable future. In the case of fright illness, these are restorative texts, elements of the overall narrative that direct, in a cyclical manner, the patient to a state preceding the incident of fright.

The prayers. As ubiquitous aspects of Q’eqchi’ medical practice, prayers (*chij*) are described to have both diagnostic and therapeutic elements. The first prayer recited by Francisco in Federico’s case is referred to as *remer* or *remerik* (i.e., “the prayer to hear or feel the pulse”). While praying Francisco held Federico’s wrists, forehead and feet, feeling the pulse and listening for a response. This initial act is primarily a process of diagnosis. Once this aspect is complete, Francisco moved on to the recitation of a second prayer called the *b’okoq mu* (i.e., “the prayer to call back the spirit of the person”). The *b’okoq mu* is specific to the current case of *kaanil* and follows from the diagnostic information received from the *remer* and other interpretive activities.

The structure of Q’eqchi’ healing prayers was once described by Manuel Choc to be like a tree. The *remer* prayer is the beginning and is like the trunk of the tree, stable and long. From this prayer the various prayer “branches” required for a specific case are determined and uttered. In this case, upon the confirmation that it is indeed a case of *kaanil* that Federico is suffering

from, Francisco moves into the *b'okoq mu* prayer to begin “calling back the spirit of the person.” In addition to this movement between the *remer* prayer and specific prayers required for each case, “Christian prayers” are often inserted near the beginning of the *remer* prayer—the “Father, Son and Holy Spirit.” Observed during the healing prayers is, thus, a fluid movement between “traditional” Maya aspects, Christian theology, and a diagnostic focus that leads seamlessly to a treatment regimen. As Emilio further described the structure of Q'eqchi' healing prayers,

When I start, I would use a church or Christian beginning. I would be calling on the Father, the Son and the Holy Spirit and Virgin Mary. When I go more into it, I would use the *kaqchikel*, like calling the sun, air, earth and darkness. *B'alam ketze, b'alam aak'ab', majukutaj, iq' b'aalam, kaqi pulumna, tojil* – are women. *Ch'omija', awilix, tz'ununija', kaqawix, kaqxe'ja'*—are the sun's wives. We would then move to the fathers – *Ajaw Tz'aqol, Ajaw B'itol, Ajaw Tepew, Ajaw KukuMatz'*—all the great fathers in *Kaqchikel*. We would then go to *Xmukane, Xpiyakok, Xchel, xkik'*, these are women in charge of the medicinal plants. Then I would move to *remer* and other prayers. That is how I would do it. I would do the Christian one first, then I would do the *remer*, then I would do the prayer for each illness, there are seven prayers I know in total for the conditions.

Like the solid trunk of a tree, the *remer* is said for every condition regardless of the particulars. Then, the healer selects which particular branch to follow based on the case at hand from the diagnostic “texts” that are read, interpreted and received. The *remer* prayer is as much about diagnosis as it is about treatment. The distinction between “diagnosis” and “treatment” in Q'eqchi' medicine is often a fluid and dialogical process, seamlessly moving from one to the other during a single therapeutic encounter.

The Q'eqchi' healers assert that the spirit and body of a person are to be in constant communion, dialogue and balance while experiencing life on the earth. The separation of these two important aspects of personhood, which can result from a frightening experience, will eventually lead to *kaanil*. After calling on the different spirits and saints in the general “Christian” prayers, and the Q'eqchi' saints and spirits in the *remer*, Francisco, during the recitation of the *b'okoq mu*, calls the spirit of Federico directly. At the same time, he asks for permission and forgiveness from *Qaawa'* and the spirits of the Mountains and Valleys on his behalf. Emilio again explained,

The *b'oqok mu*, you would start that after the *remer*. The *b'oqok mu* is to call back the spirit. I would ask for permission first from the Valleys and Mountains so that they listen to my prayer since I am just human. We would pray to his feet as to where he faltered and this is where we call the spirit [*mu*] on his four corners. What I would do also is pray on his knee with the candle. Because to kneel means to pray for your sins, and it is in the same manner, we would pray on his knees to pray for his sins where he had faltered.

Francisco and Emilio called to Federico's spirit while holding a burning candle on his knees and his feet because the possum hit his foot. As such, Francisco and Emilio spend time during this therapeutic encounter at Federico's feet, requesting that the spirit return from where it was left during the frightening incident.⁴⁰

⁴⁰ A central question regarding this aspect of the Q'eqchi' healing prayers is the degree to which the patient is aware of the therapeutic “work” of the healers and the extent to which they need to “buy in” or believe in this work for healing to occur. In many clinical encounters the healing prayers are offered so quietly that it is doubtful that the patients hear or listen to the actual words of the prayer in any meaningful way. Thus we argue that the prayers as inserted as a healing “text” into the illness drama is not so much about the specific words and language employed, but rather about the phenomenological, sensual, or performative aspects that occur. The performative and sensual aspects of Q'eqchi' healing are taken up more directly in Chapter Five. In general the *aj iloneleb'* also suggest that their healing work is effective whether or not the patient's believe in what they are doing. They approach their work analogously to biomedical practitioners, that is, that their knowledge of medicine is efficacious regardless of patient belief or understanding of the techniques involved. Although being an important issue, this dissertation will not directly comment on issues of efficacy and only loosely point to potential theoretical possibilities regarding the

In addition to calling the spirit back through prayer, Emilio explained in this excerpt that he and his brother are also requesting permission and asking for forgiveness on behalf of their patient. This is also an important part of Q'eqchi' healing prayers generally and the *b'okoq mu* prayer specifically. As outlined in Chapter Two regarding Q'eqchi' perspectives of cosmovision, a kind of “moral economy of permission” saturates the Q'eqchi' healers' visions of the world. The notions of sacrificial payments (i.e., *awas*) and offerings (i.e., *toj*) weave together with notions of *maatan* or one's day of birth in complex ways. Illness episodes like the one experienced by Federico are often interpreted to result, in part, from some kind of moral fault or “sin” that the patient consciously or unconsciously carried out, as well as the predisposition of “*yaj*” or weakness due to the day of birth. Both of these interpretive notions are laid in a moral rhetoric insofar as Federico could have performed *majejak* to alter his *maatan* and request permission at some point throughout his life. To be weak, either from birth or failing to placate the spirits, is to be immoral in many respects because one is not equipped to effectively contribute to the community in expected or “normal” ways. Federico's healing encounter thus involves asking for forgiveness and permission. It could be said that because Federico “faltered” in some way, displayed weakness that allowed him to become frightened, or conversely failed to display courage, he was susceptible to *kaanil*. Asking for permission and forgiveness during the *b'okoq mu*, thus becomes a central part of the healing encounter to return a patient “back” to his or her pre-condition state. This aspect of the *b'okoq mu* prayer becomes an important “text” that the healer inserts into the unfolding drama in the hope of altering the narrative course of events towards a more desirable outcome. In a later interview, Emilio explained,

success of the healer's work. This being said, we do suggest in following chapters that it is likely that “beliefs” in Q'eqchi' medical healing are engendered through performative and sensual aspects of the therapeutic encounter, which may play a role in the efficacy of their work.

Not everybody can get into this mistake. If you were to meet a possum, you would not get frightened; maybe it is the time that he is faltering. He did not know when this is happening. The animal is owned by the Valleys and Mountains – *Kojaj* and *Itzam*. Maybe they, the Valleys and Mountains, know why they are sending animals to frighten someone; so it would be worthwhile to ask for their forgiveness. Maybe the person has mistakes and needed to be corrected by the Valleys and Mountains. That is why one would have to ask for forgiveness. That is how you would take out the badness from him; that is why we would ask the Valleys and Mountains to help the person. During the prayer you would ask them [*Kojaj* and *Itzam*] to forgive the person and spare his life.

As can be seen here, there are certain risk factors that need to be in place in order for an individual to become frightened by an event similar to Federico's. In this way, the Q'eqchi' healers interpret the frightening incident as a kind of moral correction: the patient "needed to be corrected by the Valleys and Mountains." Thus the *b'okoq mu* prayer is like a healing "text" inserted as a moral rhetoric centered on the notions of forgiveness and permission. In this case, the *b'okoq mu* prayer acts as a narrative space where both the patient's spirit is called back from the frightening incident and permission and forgiveness are requested to ensure the future course of events unfolds in an acceptable fashion. Emilio and Francisco, through their recitation of the *b'okoq mu* prayer, expanded the clinical time of the current therapeutic encounter to embrace both historical and future aspects. The prayer as a healing "text" is concerned with writing or rewriting the patient's history, to repair the morally laden actions committed or omitted, and construct and open up a desired future course of events.

The fire and the burning. In many Maya ceremonies and medical encounters the fire and the burning of various objects is an important aesthetic activity. As Molesky-Poz (2006)

described, “Fire was a center of communication in which spiritual guides perceived facts and information. It became clear to me that the ceremonial fire is the aesthetic hearth of Maya logical and metaphysical art, a source of understanding, support, and spiritual discernment.” “Ritual involving fire,” she continued, “strengthens, balances, and invigorates the community” (p. 159). Indeed, the current work with the Q’eqchi’ Maya supports these observations insofar as the fire and the burning of sacred objects was a core aspect of *mayejak* and ritual events, especially those of healing and restoring health. In the specific case of Federico’s *kaanil*, burning the ceremonial fire involved the *copal pom*, hair and candles.

Like prayer, *copal pom* can be employed by *aj iloneleb’* for both diagnostic and therapeutic purposes. In contemporary Q’eqchi’ communities, the burning of *copal pom* is a way of offering thanks to *Qaawa’* and the spirits of the Valleys and the Mountains, as well as to strengthen the relations among humans and the other-than-human realm (Molesky-Poz, 2006). This was observed in Federico’s case. “The incense is a way to communicate to the spirits,” Francisco suggested, “It is a way we ask them to leave this patient alone. To no longer harm him [Federico] through the sickness.” “Burning *copal* to the Valleys and Mountains where the animals live is how we speak with them,” Emilio continued, “it is how they [spirits of the Mountains and Valleys] know we are here asking them for things.”

Federico’s spirit was trapped where the fright incident occurred. In order to facilitate the reunion between Federico’s body and spirit, *aj iloneleb’* must placate the Mountain and Valley spirits on Federico’s behalf, to release the trapped spirit and allow it to return. “To call back the spirit,” Francisco explained, “the prayer is not enough. What is needed too is to burn the *pom*. It must be done with the *pom*.” The burning of the *copal pom*, the scent and sounds emitted, therefore, form an important healing “text” that *aj iloneleb’* insert into the unfolding events. Like

the fire of the family hearth, there is an aesthetic warmth and comfort associated with the ceremonial fire burned in Q'eqchi' healing encounters, which becomes a "text" that helps guide and direct the illness narrative towards a more desirable outcome (i.e., strength and healing).

In addition to the *copal pom*, the Q'eqchi' healers suggest that the burning of hair or "smoking of the person" is important for fright cases of this kind, as shown in Chapter Three. In order to alleviate the fright symptoms experienced by Federico, *aj iloneleb'* suggest that hair from the animal that caused the condition must be burned under or in close proximity to the patient. "We need to smoke the person in the hair of the animal," Emilio suggested, "so the fear will be gone and the spirit can become strong." However, since it is not easy to locate the same animal that caused Federico's fright condition, *aj iloneleb'* suggest that the *copal pom* and some of the patient's own hair can be burned together for a similar effect. Emilio explained,

In the spiritual ceremony we call on the four cardinal points of the person. That animal we cannot catch anymore so that we could smoke the person in the hair of the animal. It is no longer possible since we do not know where the animal is right now. It must be done with the *pom* incense. The incense is a way to communicate to the spirits because in this way the animal is still alive. There is no way how they can go and find the animal and cut some of the hair and smoke the person with it. We can use the *pom* for this and hair of the boy to call the spirit back and stop him from being afraid any more.

In cases of fright illnesses, it is common for *aj iloneleb'* to bring in elements from the context surrounding the initial incident of fright (i.e., the hair of the animal that caused the fright).

Indeed, many healing ceremonies associated with *kaanil* and related fright conditions involve an item from the frightening event that is brought into contact with the patient or where the ceremony is performed at the actual location where the fright occurred (Bourbonnais-Spear et al.,

2007; Waldram, Cal, & Maquin, 2009). When used in this way, the comfort and safety generated during the therapeutic encounter may help to alleviate the fear or anxiety-type symptoms by fostering a kind of “desensitization” to the trauma or an “un-conditioning” of the event (Bourbonnais-Spear et al., 2005). The hair of the animal that caused the inciting incident or other contextual elements that narratively re-connect the patient with the original incident likely causes a re-writing of the illness narrative. The burning of elements during the therapeutic encounter is, for *aj iloneleb*, an important “text” to be weaved into the healing encounter. Thus, the overall narrative of the illness experience is allowed to move in desired directions, to where the patient’s spirit is “returned” and health restored.

In Federico’s healing encounter, the fire is also observed through the lighting of several ceremonial candles. In a later interview with Emilio, he explained that the candles are used “to ask for the person’s permission, for his support. That the condition “passes” and “goes away where he was frightened since it was night and that this becomes his light.” Emilio outlined,

He [Federico] was scared at night; so now we would put some light so that his spirit comes back in the light. We would use the white candle, for his spirit, for the four cardinal points, for his light and for his brightness, for water and for air. The light to guide the spirit back since it was during the night that he was scared. That is the way we are taught. It is for his support. It is only two, one for his spirit and one for his life. That is what we would ask from the Valleys and Mountains, day and brightness, from our

God; his permission. We would not break the candle, it would be whole. It is his support. In Federico’s case, the candles are important to symbolically and literally represent the light that guides or calls his spirit back. According to *aj iloneleb*, the fire and the light from the candle also become Federico’s “support,” helping to strengthen him and give him courage during this

time of illness. It is also through the burning of the candles that permission and forgiveness are also sought. After moving the candles across Federico's body, the two white candles are placed on Emilio's altar for the remainder of the healing encounter, acting as a beacon for Federico's spirit, calling it back. "We leave it there lit until all of it melts," Francisco added during a later interview, "it is left for three days to call the patient's spirit." Just as it takes time for Federico's symptoms to develop after becoming frightened early that morning, so too time is needed for his spirit to be completely called back. The candles are left to burn on the altar to aid this process and act as an aesthetic "light" and strength for Federico's current "dark" state and weakness—another important healing "text" in the overall therapeutic drama.

The herbal medications. Another prominent aspect of Q'eqchi' healing encounters is the herbal medications and use of medicinal plants. As such, the administration of these medications forms another important "text" that the healers employ to alter the patient's narrative towards desirable outcomes. The selection of plants follows logically from the reading of different diagnostic "texts" during the clinical encounter; it is based on a dialogical "fit" between the organizing principles of their "narrative genres" and the reading of specific diagnostic "texts." Once the healer is confident of the diagnosis, the medication is selected and becomes a healing "text" that aids in altering the patient's disruptive experience towards an expected outcome.

The dark green medicinal liquid that Emilio prepared for Federico was not used until prayers were offered. As Francisco explained, "We call on the Mountain's and Valley's spirits because it's on them that the plants are living." Francisco further described,

We talk to the plants because God blesses the plants to have power to heal. The first thing we say is in God's name. The reason is because it's God that made it and God give me life as well. That's why we ask God's spirit over the plant. The plants do get sad when

you're always borrowing them without giving any payment to them. It's like a worker; we can make him work but we should pay him. That's the way the plants feel.

In this excerpt from Francisco, the medicinal plants are compared to workers who need to receive “payment” in order to be happy and work well in their job. In this way, the administration of herbal medications to patients takes on spiritual and cosmological significance. Before picking the plants, mixing them in water, and offering them to their patients, *aj iloneleb*’ offer prayers and material offerings to *Qaawa*’ and the spirits of the Mountains and Valleys. In effect, they have a “conversation” with the plants while making offerings of thanks and praise for the ability to use the powers of the plants in their healing work. Offerings are made to the spirits so that the medicinal plants will be willing to cooperate in the healing endeavour and their power respected. The burning of *copal pom* in this case is, thus, not only for Federico, but also for the herbal medications. For the healers, there is no separation between the spiritual, cosmological, social or biological aspects of their healing work, as all these different “texts” come to work together in the treatment of their patients.

In Federico’s case, Francisco suggested there are two plants that are used throughout this treatment, the *chekek saq* and the *cux sawi*, both of which are commonly used for the treatment of fright illness types and *kaanil* (Treyvaund-Amiguet et al., 2005). Francisco explained,

A patient has a sickness within him, outside him, and in his stomach or in his blood.

That’s why when someone drinks the medication it goes inside the person’s body and blood. Bathing helps because it cools down a person’s body. That’s why a patient has to bathe in it also. When they bathe it also can get into the blood through the skin.

The scent of the plant also interacts with the patient. As it is poured over and cools the patient, the refreshing smell of the medicinal liquid is understood to elevate the mood of the patient:

“When someone gets sick, that person would not feel good,” Francisco stated, “It’s the scent that helps the person, especially if the medication is sweet scented. The person would feel relieved and feel good.” Thus there are multiple pathways by which plant medications can function as “texts” within Q’eqchi’ medical dramas.

Biologists and ethnobotanists have explored the use of medicinal plants and herbs among Maya communities generally and Q’eqchi’ communities in particular (Amiguet et al., 2006; Bourbonnais-Spear et al., 2007; Camporese, 2003; Kunow, 2003; Leonti et al., 2003; Medina, 2003; Nigh, 2002; Treyvaud-Amiguet et al., 2005). Previous ethnobotanical research with the Q’eqchi’ Healers Association (Treyvaund-Amiguet et al., 2005) found that the healers can treat nervous system or “mental” disorders, such as anxiety, depression or epilepsy with up to 55 different plant species. Many of these medications, especially those from the piperaceae and adiantaceae families, demonstrate important anxiolytic and/or fear suppression activity in behavioural assays (Bourbonnais-Spear et al., 2007), an important consideration for the current case of *kaanil*.

Federico’s healing encounter demonstrates that the diagnostic “texts” reveal and “emplot” the case by connecting it to a broader epistemological framework (Mattingly, 1994). In a similar way, the healing “texts” further the plot of the current case by “calling back the spirit” of the person and asking for permission or forgiveness in a complementary and overlapping manner. Like diagnosis, the healing texts are dialogical, multifarious, and intersecting. The Q’eqchi’ healing encounter intends to alleviate the current symptoms of Federico, (i.e., listlessness, anxiety, vomiting and diarrhea), and perhaps more important, helps to strengthen his moral relationships with the spirits of the Mountains and Valleys. In their request for forgiveness and permission during the healing ceremony, Francisco and Emilio asked for strength and courage to

develop in Federico, in his character and life, thereby altering his “destiny.” In this way, Q’eqchi’ healing is both teleological, that is, directed to some intended sense of the future, and historical, that is, directed to the past and to the conditions that lead to the illness state, whether that is a moral infringement, poor relations with the spirits, or the day in which Federico was born. The different healing “texts” thus interrupt the current plot of the illness episode and begin to replace it with a plot that is directed to and shaped by wellness, strength, health and balance.

Chapter Conclusions

Sigmund Freud (1920) often described his work as the repair of the patient’s story. What we have seen here by the Q’eqchi’ healers is a similar scenario, although an important distinction remains. In most psychiatric encounters envisioned by Freud (1920), or more contemporary clinical settings (Mattingly, 1994), the patient is assumed to have an important role in helping to construct the healing narrative (Harvey, 2008). In the Q’eqchi’ clinical encounter, as perhaps more reminiscent of Western biomedicine, the patient is, to a large extent, passive while the healer “reads” and “emplots” their medical drama. With the exception of the recitation of his initial illness narrative, Federico does not co-construct the therapeutic narrative in any meaningful way, at least not through the conscious aspects of language. In this way, what Mattingly (1994, p. 820) observed as the “social quality of the plot,” where patient and healer co-construct the narrative drama in an emergent and spontaneous manner, is virtually absent in Q’eqchi’ clinical encounters. In the current case, through the “reading” of available “texts,” *aj iloneleb’* discern the plot, begin to enact the healing drama, and instruct the patient where needed, all based on their “narrative genres” of similar cases.

As this analysis shows, however, the therapeutic encounter does, in some sense, unfold together, and Federico does contribute to the “emergent” properties of the plot in some ways

(Mattingly, 2000). Federico's blood is read and felt and his spirit is consulted. Through the production of different "texts," Federico plays a role in the healing encounter, although this role is different from the conscious aspect described in Mattingly's (1994) rehabilitative examples and Freud's psychoanalytic approach. As mentioned, the Q'eqchi' concept of the person extends beyond the confines of the rational or logically conscious aspects typically ascribed in Western contexts, such as those aspects of "talk therapy" central in Mattingly's occupational therapy and Western psychiatric treatment. Federico's case of *kaanil* illustrates a "talk therapy" of a different kind. It is a "social quality of the plot" not dependent on conscious, verbal aspects displayed by the patient, but rather on the communication or "talk" between *aj iloneleb'* and their patient's blood and the spirit worlds. The "person" who is engaged with and helps to "co-construct" the healing drama during Q'eqchi' clinical encounters extends beyond the confines of the body and rational mind to include the cosmological and spiritual aspects as well. In this way, we understand more fully how Indigenous knowledge and Q'eqchi' cosmovision come to bear on the clinical encounter and healing drama, widening the spheres of clinical co-construction and dialogue beyond the material and physical contexts circumscribed within Western clinical encounters.

CHAPTER V: Embodiment and Narrative in Q'eqchi' Medicine

Nestled within the Maya mountains in southern Belize rests the quiet village of Santa Cruz. Roughly two hours' drive from the nearest urban center of Punta Gorda, the inhabitants of Santa Cruz, to a great extent, live a "traditional" Maya way of life. Their water comes from running streams and their food from local farms. Their humble, thatched roof homes are communally assembled by the entire village. The close bonds between family and community are not, however, free from occasional disruptions in the social accord. The loss of a loved one, the increasing hardship of sustainable farming, changing environmental conditions, and assertive Christian missionaries can all challenge community harmony in different ways. Early in April, the eldest grandmother in a large Santa Cruz family passed away, creating distress in a community that highly values social relations. As a result, the Santa Cruz family sought assistance from Emilio to deal with the bereavement and restore harmony in the community—a somewhat typical case of *rahil ch'ool*.

Emilio Kal made the slow, winding trek from his home in Jalacte to the village of Santa Cruz early one April morning. He carried a traditional healing sack filled with *copal pom*, medicinal herbs, and several white candles. Following Emilio's directions along the windy road, our research team eventually arrived at the home of a middle-aged woman named Serena. Emilio waited patiently outside for several minutes while Serena, the patient, prepared her home for guests. Upon entering, Emilio sat on a wooden bench that wrapped around the perimeter of the home. The floor was hard-packed dirt, firm and smooth, resembling a soft cement. The main entrance space of the home was an area roughly four square meters and was divided by a wooden wall that came about three quarters of the way across the room. On the other side of the divide was the cooking area with fireplace and hearth as well as the sleeping area where several

hammocks were tied up to clear the way for daily activity. A young child peaked around the dividing wall as Serena was finishing up some household tasks. While waiting, Emilio requested a small bucket filled with water. Serena dropped it off silently. Emilio then ripped a few medicinal leaves from his healing sack and placed them in the water to prepare for the healing encounter.

After a few minutes, Serena returned with a small wooden stool and sat in front of Emilio. In most Q'eqchi' healing encounters, *aj iloneleb'* wait until a male representative of the family is present for the therapeutic encounter. For the current case, however, Emilio carried out the healing encounter while only the woman and child were present.

Without warning, Emilio began his healing words of prayer. Serena's eyes remained open, sitting slightly hunched with shoulders curled in towards her chest. Aside from the request of water and a bucket, this was their first exchange. The small girl sat beside Emilio on the same bench attentive to his quiet words. Emilio's left hand was on his forehead, his right arm bent across his knees. Emilio continued praying in this position for several minutes; he was attentive and focused. His calm was broken every few seconds with his right hand making subtle gestures toward Serena. Emilio then dipped his hand into the bucket and gently flicked a tiny bit of the liquid on Serena. Her disposition changed little. Following this, Emilio gently took hold of Serena's wrists, grasping them carefully with his thumbs; Emilio's eyes closed as he continued with his healing words of prayers. After several moments, he again dipped his hands in the bucket of medicinal liquid and grasped the tops of Serena's feet while continuing his prayers. After a brief pause, Emilio again dipped his hands into the medicinal liquid and again flicked it gently towards Serena's face. Starting at the top of her head, Emilio swiftly ran his hands over and across his patient's body, keeping them about one centimetre from her face, her shoulders,

arms, and down to her legs, never making contact—the *jilok* or “spiritual massage” seen earlier. Emilio then placed his hands gently on Serena’s feet while continuing to softly pray. The small child sat patiently beside Emilio on the bench. After twice more sprinkling the medicine and massaging her spirit, now accompanied by gentle blowing towards her head, Emilio signalled to Serena that this stage of the healing was complete.

Emilio then began discussing the medicine she required. He moved the bucket close to Serena and pointed to it several times, never making eye contact. “I was telling her how to wet her head, bathe with it and also drink some of the medication,” Emilio explained in a later interview, “she will continue this for about two days and three times a day.” After Emilio explained the treatment regimen, Serena acknowledged and left the room.

Emilio then opened his healing sack and pulled out a different medicinal herb and a small lump of *copal pom* and laid them out on the bench where Serena had been sitting. Emilio requested something he could use to burn the herbs. The small girl moved to the floor examining the bucket of medicine used in the treatment. Serena returned with a small metal pan into which Emilio placed the herbs and the waxy lump of *copal pom*. Serena then took her seat beside Emilio as he set the herbs and *pom* on fire in the metal tin. Thick, black smoke began to fill the small room. Emilio placed the pan on the floor between them and let the rising smoke envelope his patient. While the smoke filled the room, Emilio again placed his hand on Serena’s forehead and began uttering his words of prayer. Emilio’s right hand was in a fist and moved from one side to the other of Serena’s head. Emilio then removed another small piece of *copal pom* from his sack, placed it in his hand and continued to pray. He grasped his head with his other hand. During the prayers, he moved the *copal pom* close to the burning herbs and then back to Serena’s

head. While the prayers continued, the smoke whirled up between them and escaped out the side of the wood paneled home.

After about two minutes of praying with the *copal pom* and holding Serena's head, Emilio picked up the metal tin and fanned the smoke into her face. Prayers continued. Another brief moment passed before Emilio placed the metal tin in the corner of the room and came back to the woman. He then removed a small bottle of *agua de florida* from his back pocket, a tincture of scented flowers and spices, sometimes referred to as "spirit water" by the Q'eqchi' healers. Emilio took a small amount of *agua de florida* into his mouth, then sprayed it onto Serena's face and body. Emilio repeated this twice, after which the room smelled slightly of alcohol and *copal* incense.

Emilio then signalled that his work for today was complete. He further explained the medicinal plants to Serena and she picked up the small bucket containing the medicinal liquid. Again there was no eye contact made between them. Emilio packed up his things and wiped the sweat from his forehead. Emilio and Serena exchanged words for another few minutes before leaving. The young girl smiled and waved goodbye.

Embodiment and Narrative

As argued so far, the Q'eqchi' healers work as "readers" of their patients' "texts," undertaking a dialogical interpretive process. This process involves moving between the cultural logics underlying their cosmovision, the abstract generalities of different "narrative genres," and the particular signs and symptoms read as various "texts" within a specific case. "Circling between the available clues and the general rules that define disease," Hunter (1991) observed, "the medical reasoner generates a full and plausible set of possibilities, discards those that are not

borne out by the ‘facts,’ and thus, even in the absence of a confirming test, arrives at the best hypothesis for the case at hand” (p. 66). Similarly, Montgomery (2006) argued that,

Because the day-to-day diagnosis and treatment of sick people is an interpretive process, physicians go on relying on the narrative organization of details in a reasoning process that starts “bottom-up,” or inductively from the particulars, and then circles between those particular observations and general rules, fitting the details to the patterned whole and testing the details in light of the known generalities (p. 130).

As Hunter (1991) and Montgomery (2006) observed with Western physicians, our research team argues that the Q’eqchi’ *aj iloneleb*’ treat and assess medical cases through a clinical reasoning that relies on the ultimate casuistry of narrative. The “general rules,” “patterned whole” and “known generalities” Montgomery described are, for the Q’eqchi’ healers, the “narrative genres” and local understandings of cosmovision which, to a great extent, inform and guide the dialogical “reading” of any particular case.

This process of inductively and dialogically circling between particular “texts” and the epistemological structures of illness also reflects what Flemming and Mattingly (2008) refer to as “narrative reasoning” or a reasoning process in which a healer “sees events unfolding as an organized drama, with a cast of characters, motives, themes and surprising turns of events, a plot structure” (p. 59). Further, narrative reasoning in clinical settings asks “what story the patient is in” and “concerns the relationship among motives, actions, and consequences as they play out in some specific situation” (p. 59). When Emilio attended to Serena’s case of illness, he dialogically compared her symptoms and story with already known narrative structures. Thus, he identified or “emplotted” her story and discerned what therapeutic processes would likely be required (Mattingly, 1994). Narrative reasoning, therefore, is also “directed to the future in the

sense that it involves judgements about how to act in order to “further the plot” in desirable directions and subvert, as far as possible, undesirable ones” (Flemming & Mattingly, 2008, p. 60). Narrative reasoning allows *aj iloneleb*’ to comprehend a complex flow of action and to act appropriately within it. They “read” a confluence of various and, at times, contradictory “texts” and co-construct plausible endings.

Chapter Four explored two “texts” that Q’eqchi’ healers “read” to determine and “emplot” specific cases of mental illness and disorder: the blood pulse and the *copal pom*. This chapter focuses specifically on how bodily knowledge or “somatic attention” (Csordas, 1993, p. 135) informs the “reading” process while also looking to the body as an additional “text” that healers employ to “enfold” illness experiences into their narrative genres of mental illness and disorder (Mattingly, 1994). Thus, several key questions are asked: What are the different kinds of embodied knowledge on which the Q’eqchi’ healers rely to situate or “emplot” a specific case within their narrative genres of mental illness and disorder? How do the narrative genres of Q’eqchi’ mental illnesses play out at the site of the body? Are the different narrative genres merely enacted as cultural scripts during therapeutic encounters, or are the Q’eqchi’ healers somehow attuned to the “emergent” or embodied properties within a specific case? How do the performative, embodied, and non-verbal aspects of Q’eqchi’ therapeutic encounters relate to the processes of narrative reasoning and emplotment outlined above?

Previous research and theory in psychological and medical anthropology generally assumes a discontinuity between stories told and lives lived; that is, between narratives and experience. When attempting to describe one view of human intersubjectivity in terms of the other, authors generally agree that much is lost in the process (Bruner, 1984; Desjarlias, 1992; Good, 1994; Mattingly, 2000; 2010). “There may be a correspondence between a life as lived, a

life as experienced, and a life as told,” Bruner (1984) observed, “but the anthropologist should never assume the correspondence nor fail to make the distinction” (p. 7).

Mattingly (2000) furthered this line of thinking by exploring two major perspectives in contemporary theory: naïve realism and semiotics. From the view of “naïve realism,” Mattingly showed how several authors contend that narratives do not mirror embodied life as lived because life, and the spontaneity of our day-to-day experience, is generally not shaped by a plot and does not involve a narrator to the same degree as are found within narratives. The phenomenological and embodied aspects of our daily life do not follow the same “temporal frame” as the teleological structures of narrative, which, unlike life, “begins at the ending” (Mattingly, 2000, p.183). Mattingly outlined that it is generally the ending that shapes our telling of a story, of what to include and where to stop. However, day-to-day life is clouded with a degree of uncertainty regarding how things will end; we can only understand the significance of each passing moment in light of some imagined or hope-filled future (Mattingly, 2010). Narrative, from this view, is a mere imitation of the phenomenological complexities and temporal ongoingness of life as lived (Bruner, 1984).

With regard to “semiotic positions,” it is generally held that narrative acts as a kind of cultural script that guides individual behaviour, embodiment and meaning-making processes of cultural actors. Narrative, from this position, reflects context-independent texts which point to or locate cultural signs and symbolic systems of which they are a part. Here, narrative is viewed not simply as a retrospective account of prior actions, but rather a kind of social character and cultural script that shapes behaviour and meaning. Narrative becomes equated with the sequential and formulaic vision of social action. Mattingly (2000) noted, however, that objections are posed against this “action-as-text metaphor” on the grounds that social action and

cultural performance are reduced and oversimplified when interpreted strictly in narrative terms (p. 186). In this scriptural rendering of performance, that is when viewing cultural action solely through a semiotic or narrative lens, several authors have argued that the phenomenological experiences (i.e., sensual, embodied and non-linguistic aspects) are missed (Csordas, 1997; Desjarlias, 1992; Howes, 2003; Jackson, 1989; Jenkins, 1991; Kleinman & Kleinman, 1994; Nichter & Nichter, 2003).

Whether viewed as naïve realism or semiotics, it is apparent that there is opposition between a narrative rendering of experience on the one hand, and a phenomenological, embodied, or performative rendering of experience on the other. Both these perspectives assert that a distinction must be made between the embodied experience of a certain event and how that experience is communicated narratively. Specifically regarding the interpretations of healing and illness experiences, several tensions are observed in contemporary literature involving a narrative, discursive, and language-based perspective versus a non-discursive, performative or embodied perspective (Csordas, 1994; 1997; Desjarlias, 1992; Stoller, 1997). Do these two positions meaningfully relate to one another? Does the narrative rendering of experience involve an embodied or performative dimension? Along these lines Mattingly's (2000) question is particularly insightful: "How do we see narrative in terms of life and life in terms of narrative without loss of richness and complexity, without neglecting the phenomenological complexities of lived experience and the creative artifice of narrative?" (p. 188).

Perhaps due to the analytic gap between embodiment and narrative, the body, as site of experience and knowledge, receives little attention in exploring processes of "narrative reasoning" amidst clinical encounters (Hunter, 1991; Montgomery, 2006). It is argued throughout this chapter, then, that the "narrative rationality" described by Hunter (1991) and

Montgomery (2006), and the “narrative reasoning” outlined by Flemming and Mattingly (2008) both involve bodily forms of intuition-based somatic knowledge that guide the dialogical “reading” of medical “texts.” From here it will be demonstrated how bodily sensations that Q’eqchi’ healers’ experience during therapeutic encounters can also be considered a distinct “text” serving to “emplot” or “domesticate” patient experiences (Becker, 1997; Mattingly, 1994). Far from being the enactment of prior narrative scripts, this chapter illustrates how “narrative genres” can emerge through bodily interactions and improvised narrative acts. In this way, it is suggested that the dialogical “reading” of various “texts” within a particular case—a reading process that occurs within the contexts of an epistemological structure of “narrative genres”—follows Mattingly’s (2000) reflections regarding “emergent narratives.”

In her work Mattingly (2000) contended that

Emergent narratives...are not the routine enactments of prior texts but are improvised as well as embodied. They are usually invented more or less on the spot, unrehearsed dramas that spring up in the course of everyday activity. Of course, an emergent narrative does not spring up from nothing. It is a cultural act, and its creation depends upon a complex repertoire of cultural resources. Actors draw upon familiar cultural stories and scenarios, though these provide merely decorative starting points, skeletal plots at best. Improvisation is not merely decorative or incidental; it is the process by which a skeleton is transformed into a flesh-and-blood event. To read improvisations as re-enactments of the canonical or the routine is to miss the whole point (p. 205).

In working with the Q’eqchi’ healers, a similar improvisational and emergent process is observed. The “improvisation” of each healing encounter is based on known genres; a “complex repertoire of cultural resources” with “familiar cultural stories and scenarios” that provide

skeletal plots for the actual therapeutic encounter and overall treatment regimen (Mattingly, 2000, p. 205). Observed through this view of “emergent narratives,” the gap between narrative and embodiment can be bridged. It can be appreciated that Q’eqchi’ narrative genres as embodied, improvisational, and fitted to context can align with performative views of embodiment and social action. This makes it possible for us to explore the narrative components of performative events, while observing the non-narrative performance at the center of the narrative genre. This chapter thus focuses on the “body as text” while exploring how a process of dialogically “reading” a clinical case can be interpreted within a broad paradigm of “embodiment” (Csordas, 1990). In so doing, the relationship between embodiment and narrative generally, or discursive and non-discursive aspects of subjective and intersubjective experience specifically, is questioned (Bruner, 1984; Csordas, 1994; 1997; Desjarlias, 1992; Mattingly, 2000; Stoller, 1997).

To situate these reflections, this chapter begins by exploring Emilio’s and other healers’ perspectives of Serena’s case of *rahil ch’ool* and the “thinking too much” narrative genre outlined in the opening sections. This first section examines how the Q’eqchi’ healers understand and interpret experiences of sadness (*rahil*) that, from time to time, take on pathological tones. The next section explores how the body can be conceptualized as an additional “text” that the healers read and interpret during their healing encounters. This leads into a discussion of how the body as a site of experience and perception aids the “reading” of various “texts.” Here it is argued that “reading” a case and processes of narrative reasoning necessarily involve somatic forms of intuitive-based knowledge. This chapter concludes with overall reflections on the relationship between embodiment and narrative, making a case for how the “narrative genres” outlined in Chapter Three are dialogically and performatively improvised as well as embodied.

Experience and Treatment of *Rahil ch'ool*

The opening section of this chapter described the death of a grandmother in a large Santa Cruz family that left her children and grandchildren in various stages of bereavement. For some this was seen as a natural transition from the earthly world to the spiritual; their emotional, psychological and social functioning during mourning remained interpretably “normal.” These family members participated in typical Q’eqchi’ burial ceremonies and community gatherings. Shortly thereafter they returned to daily routines, occasionally reflecting on the life of their mother and grandmother—successful cultural processes in the “work of mourning” (Desjarlias, 1992, p. 143). For others in the village, however, the adjustment to the change in social dynamics was more difficult, and the initial period of “normal” bereavement began to negatively impact day-to-day activity.

This is the story of Serena. For several months after the burial and family ceremonies honouring her mother, Serena remained sad and depressed. This negative mood eventually turned into a more serious, generalized anxiety that began to restrict Serena’s regular household routines and social activities. Eventually, she also developed stomach pains and poor appetite. At that time, Emilio was contacted for assistance. It was Serena’s husband who initially contacted Emilio, explaining to his *aj ilonel* friend what was occurring in the family home. After only a brief investigation of Serena’s case, involving a description from her husband and an initial meeting with Serena, Emilio promptly identified her disruptive experiences as *rahil ch'ool*.

The illness known as *rahil ch'ool* means “sadness of the soul” or “depression.” This state of sadness can result from the loss of a job, death of a loved one, or quarrel with one’s spouse or close family member. Central to the changes of one’s internal disposition is a style of thinking,

or “thinking too much,” that is, ruminating on a negative situation in such a way as to subsume one’s being with negative mood and affect.

For Serena, the family and social dynamics in her village changed suddenly due to the passing of her mother into the spiritual worlds. Serena then began “thinking too much” about this situation. Her mind and heart became “weighed down,” “slow,” or “heavy” by the social misfortune experienced—all common idioms or metaphors used by the healers and translators to communicate her experience.⁴¹ In general, the Q’eqchi’ healers describe the symptoms of *rahil ch’ool* to include an overwhelming amount of sadness, rumination, debilitating lethargy, listlessness, suicidal ideation, fatigue, significant loss of energy, and diminished cognitive ability (see Table 7 in Chapter Three).

As described previously regarding Q’eqchi’ metaphysiology, thinking occurs in both the heart (*aam*) and the mind (*k’a’uxl*). Thus, it is important to remember that “thinking too much” as described in the specific case of *rahil ch’ool*, or more broadly in the “thinking too much” narrative genre, involves both the heart and the “mind” of the person. The blood is also important here as it is how one’s thoughts, by way of the heart, are distributed through the entire body and onto the social world. The blood therefore is largely responsible for the body’s animation. The internal state of the blood is determined through pulsing activities and by observing these individuals as they perform their daily social routines. “Their blood will be really sad or moving slow,” Lorenzo suggested for cases of *rahil ch’ool*. The sadness generated by “thinking too

⁴¹ There was one conversation with Serena during our ethnographic work in Belize. However, this was not recorded as she preferred to speak with us without the use of audio recording. While explaining her current state and feelings, Thomas Caal used the English words “depressed,” “weighed down,” “slow,” and “heavy” to communicate her experiences and feelings that have grown on a day-to-day basis. These phrases also later appeared in the healer’s descriptions of *rahil ch’ool*. It is interesting to note these are also common metaphors or idioms used by women experiencing depression in Western contexts (McMullen, 1999).

much” about social misfortune slows the blood flow, which, in turn, causes the person’s movement in the social world to be “sad” and “slow.”

For many Maya communities throughout Central America, the blood is also described as the location of the person’s spirit or soul (Fabrega & Silver, 1973; Groark, 2008; Holland, 1962; Rojas, 1947; Tedlock, 1982; Vogt, 1969). Similarly, Francisco reasoned, “once you’re talking to the blood it’s like you’re talking to the spirit.” Emilio also explained that “we talk with the spirit of the patient by talking to the pulse.” From here it is more correct to say that the blood is largely responsible for the body’s animation only insofar as it is the vehicle for the human spirit or soul. The “dialogue” in pulsing activities, therefore, occurs more so with the spirit or soul of the person than with the “blood” per se.⁴² It is the spirit, as manifest in the blood of the body, that responds to the healers’ query. All of these factors are implicated in the literal translation of *rahil ch’ool* to “sadness of the soul” or “depression,” a condition where the spirit or soul is “sad” or slow moving as depicted by the state or quality of the blood.

Further in Q’eqchi’ theories of metaphysiology, moods and emotions are not solely the “psychic” property of individuals alone.⁴³ In their descriptions of several illness conditions, *aj iloneleb’* often suggest that the experience of a negative mood is the consequence of an “evil spirit” within the body and blood. Spirits of all sorts in Q’eqchi’ cosmovision can function as external agents who “take over” or seize control of the mood, behaviours, or emotional states of a person: “it is the spirit that bring the anger,” Emilio explained. In this way, emotions (*xch’ool*) involve the ethereal qualities of the soul (*ch’ool*) or human spirit, and are closely related notions

⁴² See discussion regarding “reading the pulse” in Chapter Four.

⁴³ See also Grossen’s (1999) discussion of Maya “metaphysics of personhood” (p. 244), or Groark’s (2008) reflections on Maya anatomy.

as witnessed in the similarities of their Q'eqchi' spelling.⁴⁴ Moods and emotions are unseen forces that, like the plethora of Mountain and Valley spirits, operate on human experience in complex ways. Unlike cases of fright where the spirit is trapped or “lost,” discourses of emotional distress, or extreme sadness like the case of Serena, are often coupled with notions of “presence”—an additional spirit or “otherness” that is with the person (Harvey, 2006; Groark, 2008). In this way, moods, like various spirits, are thought, under certain conditions, to envelope a person. Like the many spirits inhabiting the environment, moods and emotions can overpower people, take control and become all-consuming; they can alter someone's “normal” behaviour and their ability to effectively perform daily activity. Moods and emotions, again like spirits and souls, can occupy individuals as well as social spaces, lingering in abandoned buildings, uninhabitable homes, dark corners, or individual minds and bodies where “thinking too much” seems to abound.

This notion of “presence” in Q'eqchi' discourse also reflects a notion of agency. Illness disturbances of various kinds are often described by *aj iloneleb'* and Q'eqchi' community members as a volitional force or “other” that acts on the person from the outside and that needs to be “taken out,” “taken away” or removed. A similar logic is expressed for thinking and emotional illnesses or “mood disorders” such as *rahil ch'ool*. The sadness that is experienced is thought to have a force, an agency, and correspondingly the healers' discourse centers on the need to “take out” the spirit of the sickness.⁴⁵ “To take out the bad spirit,” Francisco described, “I use a medicinal plant...smoke the person, and I blow in the face to take out the spirit and fix his

⁴⁴ In Q'eqchi', the human soul or spirit (*ch'ool*) and emotions (*xch'ool*) are closely related notions. The “x” here in Q'eqchi' is used to transform the noun of soul or spirit (*ch'ool*) into a verb or to express the active quality of emotional states (*xch'ool*). Thus emotions are often seen as the actions of the soul or spirit in the world.

⁴⁵ This is also observed through practices of bloodletting that can, on occasion, occur among Q'eqchi' communities. When understanding that some sickness can involve an additional spirit that is residing with or impacting a person in severe ways, and that the blood is seen as a tangible expression of or location for the spirit of a person, we can appreciate bloodletting as a logical practice of “taking out” the harmful or “evil” spirit that is impacting the person.

life.” Similarly, Lorenzo suggested that for *rahil ch’ool*, “The use of the rum is to take out the sickness or the spirit that is within the person by blowing it over his head.” Or as Emilio observed, “We blow over the patient so that the spirit gets out because he is affected by a bad spirit and we have to pray and smoke him.” “You would tell them [evil spirits] to leave the patient alone,” Manuel Choc outlined regarding the use of healing prayers, “so that they [evil spirits] go away in the name of God...When the evil spirit comes out, the person is cured.” And as Manuel Baki agreed, “You can use the prayer to take away the bad spirits to leave the person. You’ll do it in that form [prayer] so the spirit goes away.”

Mood and affective disorders like Serena’s are thus thought to involve a force beyond the control of the individual, an “evil spirit” of sorts that impacts the person’s thinking, mood state, and behaviour. The emotional states and dispositions that are interpretable as “abnormal” and therefore warranting some form of therapeutic intervention often come about through ways “other” than or external to the individual. To be more precise, the “thinking too much” or dwelling on the social misfortune is an initial event, a fault or “sin” in the vernacular of a “moral causal ontology” (Shweder, 2003), that, to a great extent, opens the way for the “evil spirit” of depression to envelope or consume the person. In a sense, then, “thinking too much” is considered both a “mental” disorder and its cause.

Almost every account of severe depression (i.e., biomedically based psychiatrists, autobiographical experiential accounts, or the Q’eqchi’ healers narratives) includes reference to changes in mood or feelings that are inextricably bound up with profound alterations in how one finds oneself in the world. Martin Heidegger (1996) argued that mood [*Stimmung*] makes a substantial contribution to the sense people have of belonging to a world. Heidegger (1996) further contended that our moods are a kind of disposition (*Befindlichkeit*) that possesses an

ontological capacity; that is, they can colour a whole world. Being in some mood or other is an essential human way of being in and having a world. A mood, for Heidegger, does not add emotional colour to pre-given objects of experience. We can only have objects of experience insofar as we already find ourselves in a world, and we would not find ourselves in a world at all without mood. Unlike the acts of perceiving, believing, desiring, or remembering, a mood is not an intentional state directed at something within the world. Instead, it is a condition of possibility for such states. Moods and emotions are neither “cognitive” in the traditional sense nor mere “affects,” but, as Heidegger suggested, a background that binds us to the world, anchoring us in a context of goals, projects and relevant environmental patterns. Moods and emotions constitute a sense of “belonging” or “attunement,” a basic feeling of orientation, of being, without which explicit cognition could not occur. Thus, moods are not conceptualized as “subjective” or “psychic” phenomena but part of the “pre-objective” background relative to which the world and the manner in which we are situated within it is disclosed to us or rendered intelligible. A mood comes neither from the “outside” nor from the “inside,” but is a dispositional capacity directing us toward the world.⁴⁶

This “pre-objective” formulation of moods is, in a way, an attempt to move beyond any subject-object or internal-external distinctions in the analysis of mood states and emotions.⁴⁷ Looking at moods as a kind of pre-objective disposition, a way of being-in-the-world, allows us to understand the Q’eqchi’ healers’ assertions that emotions and moods are spirit-like entities that can “take over” and envelope an individual in disruptive ways.

⁴⁶ Here Heidegger is addressing the assumption held in western discourse and particularly in contemporary psychological thought that mood is an internal, subjective psychological state that can be inferred from posture and other behaviours. From this position, which is inextricably bound to the notion of the egocentric self that abounds Western contexts (Kirmayer, 2007), individuals have moods and emotions that are different from other individuals and that the emotional content is contained, more or less, within the individual—that is, under their skin.

⁴⁷ The concept of the “pre-objective” is further developed in later sections of this chapter.

Going back to Serena's case, she does not experience a certain "evil spirit" within herself. Rather, she experiences particular thoughts, behaviours and emotional states coloured by sadness and grief that impact her ability to effectively be in the world (i.e., *rahil ch'ool*). Serena's mood alterations are not felt as part of the "normal" intentional actions she performs on a day-to-day basis. The ongoing and lingering "presence" of these moods and dispositions eventually lead her and her family members to request assistance from Emilio. Because, as Heidegger argued, moods operate in the ontological background of our dispositional character, they carry with them a certain kind of "otherness." In this way, the pre-objective change in Serena's mood is interpreted by Serena and Emilio as a "presence" of volitional "evil spirits."⁴⁸ Moods, like spirits and souls, are given a certain agency of affect in Q'eqchi' discourse, which signifies changes in disposition at the pre-objective level of being in the world; that is, changes in one's body (Niedenthal, 2007). Thus, the healing conditions that involve perceptual changes in mood states do not necessarily involve the patient's individual "self" to a significant degree. Rather, as observed in Serena's case of *rahil ch'ool*, the main actors are the spirits that impact or cause the change in the person's behaviour, and the blood which is the seat of these spirits in the body and the vehicle for "thinking too much" conditions.⁴⁹

Therapeutic attention in Q'eqchi' healing is on the "spirits," on the tacit aspects of a person's bodily disposition and a generalized and historized way of being-in-the-world (Kahn, 2006). The modality through which this aspect of the patient is addressed, that is, the manner in which the "spirits" are "taken out" or removed in Q'eqchi' healing encounters, is through a focus

⁴⁸ From here we see how Csordas (1990) argued that the healer could function as a specialist in "cultural objectification," interpreting changes in moods and emotions at a pre-objective dispositional levels as an "otherness" from the spiritual world.

⁴⁹ From this view, then, in helping a patient discover his or her "true self" the Western-trained psychiatrist or PNP working in Belize, may, in fact, be promoting a cultural construction of the "self" and personhood that is untenable within the Q'eqchi' patient's local social world (Harvey, 2008; Kirmayer, 2007). Understanding the ways in which Q'eqchi' individuals may construct a sense of personhood out of their local environment and cosmovision is thus important to counter the pervasive assumption that Western perspectives of the "self" are ubiquitous and universal.

on the existential immediacy of the lived body. By addressing the level of bodily disposition through the performative and sensorial aspects of Q'eqchi' healing (i.e., burning the *copal pom*, holding the wrists, uttering healing words of prayer, bathing and drinking herbal medication), alterations in mood and a generalized “thinking too much” can occur. In many cases, then, the healers' invocation of “spirits” reflects an analytic focus at the pre-objective level of bodily practice (Csordas, 1997).

As pre-objective bodily practice is ontologically associated to the world of “spirits,” one can more fully understand why there are limited verbal exchanges between patients and healers during Q'eqchi' medical encounters. There are no explicit attempts to “educate” the patient regarding the symbols or metaphors employed during Q'eqchi' therapeutic interactions. Rather, the patient is passive in the process as the body and “evil spirit” of the illness become the loci of therapeutic intervention. In this way, the patient is more often than not a mere witness to the medical drama. *Aj iloneleb'* rarely attempt to involve the patient's individual “self,” including their beliefs, meaning making processes, or “mind,” to any significant degree. Serena is not a “participant” in the healing encounter in the true sense of the word. Instead, it is the pre-conscious, pre-objective or embodied level of “evil spirits” and cosmological forces that captures Emilio's medical attention.⁵⁰

In some sense Serena is not responsible for her condition. Yet, the Q'eqchi' healers acknowledge that the difference between people in Santa Cruz who became ill as a result of the

⁵⁰ Here we start to see how Q'eqchi' healing may be somewhat closer to processes in biomedicine rather than models of “symbolic healing” (Dow, 1986). Biomedicine, like Q'eqchi' healing, is understood to “work” independent of belief. In this the cultural work of *aj iloneleb'* is like that of biomedical practitioners who operate independent of the belief, meaning or “mind” of the patient. The patient need not understand notions of Q'eqchi' cosmovision or “narrative genres” any more than a patient in biomedicine must understand the scientific logic underlying a surgical procedure or the chemical interaction involved in a pharmaceutical treatment for depression. The patients' role is ontologically similar in both Q'eqchi' healing encounters and many aspects of Western biomedical practice, as both generally assume that a certain treatment “works” independent of belief or knowledge of the process.

social misfortune and those who did not is related to their ability to “accept” what has happened, a notion related to a concept of personal agency or responsibility. If you can accept change, it is said, you are likely to prevent the onset of “thinking too much” and thereby developing any kind of extreme form of sadness. Indeed, Manuel Choc explained, “The one that doesn’t get sickness just accepts the death of his mother while the other one just grieves a lot, he’s just sentimental and doesn’t accept the death. It becomes a sickness when the person does not stop worrying about and what he is thinking about. It becomes serious.” In a similar way, Francisco suggested,

The one who doesn’t think about it much and understands that all of us have to die, that person would be less affected by grief. But the one who thinks about it most will be most likely affected more because he continues to think about it, and the depression [*rahil ch’ool*] would be more, and thus he will get sick and tired of it affecting him in his life.

There is a tension that arises here between the illness agency of affect, on the one hand, that is the notion that negative mood states can come over and envelope the person, and the individual agency and responsibility to “accept” their condition, on the other. Although the individual’s role is acknowledged, *aj iloneleb’* more often than not emphasize the illness agency of affect over that of the patient’s. This is witnessed most clearly in the actual therapeutic encounters where *aj iloneleb’* focus their therapeutic attention on the illness state and “evil spirit.” Because healers conceptualize the role of spirits in causing illness states and the general theory of mood and agency of affect, they often look away from rather than into the patient during the “reading” of different “texts.” At the same time, this understanding of the role of spirits and mood states allows us to appreciate why the patient, in Q’eqchi’ healing dramas as observed in Serena’s case of *rahil ch’ool*, oftentimes assumes a marginal or passive role.

Body as “text”

In the practice of Q’eqchi’ medicine, there are several “texts” that the healers “read” to interpret and situate a specific case within their narrative genres of mental illness and disorder. From this perspective, the body comes to view in two important ways: the body as an additional “text” that the healers employ to interpret and “emplot” illness experiences within a specific case; and the body as a diagnostic tool that assists in the process of “reading.” This “body as text” section outlines the first and the following section outlines the second.

It is common for *aj iloneleb’* to describe sensations within their own bodies during healing encounters that provide important diagnostic and prognostic signs or information about their patient. These “bodily sensations” are additional “texts” that are read and interpreted in Q’eqchi’ medicine. As discussed in the previous chapter, our understanding of “text” is anything containing a coherent set of signs and symbols that can be “read” by *aj iloneleb’*, and that which signifies or helps to construct the plot of a particular case. In this way, bodily sensations coalesce with the patients’ narrative and symptomology to further “emplot” or locate a particular case within the epistemological framework of their narrative genres (Mattingly, 1994; 1998). In many ways, then, the bodies of the Q’eqchi’ healers act as both a diagnostic instrument and a text; an instrument that produces the text.

Across a wide variety of ethnographic literature among Maya communities in Central America, references to bodily sensations in medical practitioners or “spiritual guides” are recorded (Molesky-Poz, 2006). During their work among the Kiche Maya peoples of Guatemala, Rodas, Rodas, and Hawkins (1940) mentioned that when a spiritual guide or diviner was praying, “if his left armpit twitches, that is a bad sign while if his right arm pit twitches that is a good” (p. 7). A few years later, Bunzel (1952) observed within the same Guatemalan Maya

community that during divinatory practices, like seeking advice on dates for a marriage or planting crops, the spiritual guide would ask a series of questions of the patient until suddenly “answered by a twitching sensation in the forearms, which is said to be located in the veins, and to be the voice of the blood” (p. 5). This sensation in the diviner’s body was described by Bunzel to be the manifestation of the spirit speaking through the diviner’s blood, an ability said to be a direct gift from the ancestors or spiritual worlds (Bunzel, 1952). Similarly among the Quiche Maya of southern Mexico, Salor (1973) described “that ‘twinging’ of blood in the legs of specially gifted persons, [with] the pulsations being interpreted according to some scheme for yielding binary answers—‘yes’ or ‘no’—to any question” (p. 3) was a central aspect of divinatory and medical practice. This “twinging” as Salor described it was thought to be the material representation in the body of a spiritual “conversation” with the wellness-seeker’s spirit. Some years later in the highlands of Guatemala, Tedlock (1982) also observed many instances where the “lightening in the blood” was seen to “speak” and communicate to a particular healer or spiritual guide. Variouslly described as “twitching,” “jumping,” or a “tingling” in the blood and muscles, Tedlock suggested these bodily sensations convey information about the past or the future prospects of the medical patients or divinatory clients. Interpretation of these sensations, or “lightening movements in one’s body,” is taught directly, Tedlock (1982) noted, “through myth-telling, prayer-making, and dream analysis, but above all through direct discussion of the movements actually experienced by the novice and the teacher while they are together” (p. 139).

During investigations into contemporary Maya spirituality among the K’iche’ in Guatemala, Molesky-Poz (2006) also observed how a Maya healer or spiritual guide can have regular “communications” with the spirits in the natural world (p. 75). These communications produce material signs in one’s body. Through ritual practice and ceremony during training

periods, an initiate into the Maya medical and spiritual worlds develops contact with and a relationship to a tremendous form of spiritual energy. “Through this ritual practice,” Molesky-Poz (2006) explained, “the initiate learns to overcome personal fragmentation, to gain a particular spiritual strength and psychic understanding so that he/she will become capable of healing others in ritual” and “also begin to receive and learn to interpret different manifestations of energy” (p. 75). These manifestations of energy can include many forms, from dreams and divination (i.e., in reading *copal pom* or *tz’ite* beans), to perceiving the signs of the flame during ceremonial fire, or recognizing the signals that are awakened in the body, or the “lightening in the blood” Tedlock (1982) described. Through healing encounters and ritual practice, the newly initiated *aj ilonel* or spiritual guide begins “attuning to the signs moving within his/her body” (p. 79). As they “tend to the corresponding signals in their bodies” (p. 155), they become proficient at interpreting and understanding the spiritual and embodied modes of apperception that are central to their craft. As Molesky-Poz (2006) concluded, these “signs” in the human body are “manifestations of spiritual energy” (p. 81), which “comprise texts to perceive, but more accurately, to engage with and translate” (p. 155).

Although receiving frequent mention in previous ethnographic literature, the extent to which these bodily sensations among Maya healing practitioners or spiritual guides have been systematically linked with an epistemological structure of a localized healing practice remains limited. This rich literature is expanded and developed by situating the bodily practice of “somatic attention” (Csordas, 1993, p. 135) or “empathetic intercorporeality” (Harvey, 2006, p. 909) within the narrative genres of Q’eqchi’ mental illness and disorder while demonstrating how *aj iloneleb’* employ the body as an important “text” to be perceived, engaged with and translated (Molesky-Poz, 2006).

As the healing session begins with Serena in her Santa Cruz home, Emilio remained crouched with his left hand resting on his forehead while quietly praying. It is during this part of the healing encounter where the Q'eqchi' healer is attentive to his own body, listening and perceiving any form of "twitching," "jumping," or a "tingling" in his blood and muscles. After a few short moments Emilio lightly held Serena's wrists to "read" her pulse while attending to any movements that might occur in the blood or in his body as a response to his healing prayers. "When I first get hold of her," Emilio described in a later interview, "this part [pointing to his lower chin] shakes or moves, then it goes to my back." Emilio continued, "When you're healing, [if] this part [lower chin] shakes that means that you're sure you will help." Describing these bodily sensations again Emilio explained, "It can tell me if it's a sickness or not," and that "those movements are what help me to know what else to do and how to take another step."

For both Emilio and his brother Francisco, who were at the time of this research undergoing training to become "spiritual guides" (Molesky-Poz, 2006),⁵¹ these types of bodily sensations are primarily interpreted to provide prognostic information about the patient. The movement on his lower chin suggested to Emilio that Serena is on the path to recovery through their healing interactions. Here the "body-as-text" is primarily about how the patient is doing, about what is needed in each specific case to "further the plot" in desirable directions and "subvert, as far as possible, undesirable ones" (Flemming & Mattingly, 2008, p. 60). As Francisco similarly mentioned for a separate case, "When we're doing something good, this part of my body [cheek or top of hands] will trigger. Or if not, [if the patient is not doing well], then

⁵¹ This practice of interpreting bodily sensations was not recorded in any significant details by the other members of the Q'eqchi' Healers Association. Some of the other healers acknowledged that such an interpretation of bodily sensations are possible but that they were not proficient at this practice. With the exception of Augustino, Francisco and Emilio were the only healers describing this process in detail. As Molesky-Poz (2006) observes, interpretations of these bodily sensations is possibly a practice and skill more closely aligned with "spiritual guides" than healers per se.

it's this part that will trigger [back part of behind the legs] and it could be that the patient won't get better." Or Francisco later described, "When you get a feeling like I tell you [movement on the cheek], that means that the prayer is working." "Sensations give some information," Francisco explained, "if your arm gets a feeling then that means that everything is going good, but if it's your back then that means that the patient might not get cured because it is a negative sign." Along these same lines, Emilio suggested that regarding a patient experiencing a "thinking too much" condition,

If the Valleys and Mountain want an offering with this illness then this part will shake for me, my lips and under my chin. I get this sense when I'm holding the person's head. This means that I'll have to do an awas [sacrificial ceremony] with this person, using some cocoa, or *agua de florida* to blow on the person. That's the way I see it.

Bodily sensations help to explicate the current case in that they allow *aj iloneleb'* to know how specific therapeutic elements employed are acting to further the plot. Bodily sensations provide immediate feedback to the healer about the treatment progress. If it is the first therapeutic encounter, bodily sensations suggest what may be the most appropriate and timely means to a cure. In Serena's case, these bodily sensations allowed Emilio to "know what else to do" and guided him to "take another step." In other words, these sensations assist the healer to appropriately select from their repertoire the most effective healing technique. Whether or not the spirits of the Mountains and Valleys require a specific offering, or if "the patient might get cured," can be known through the "texts" of sensations arising within the healer's body.

As opposed to the "blood-as-text" aspects of Q'eqchi' medicine developed in Chapter Four that were primarily about "therapeutic emplotment" and diagnostic in nature (Mattingly, 1994), the "body-as-text" aspect is primarily about "therapeutic improvisation" and prognostic in

nature. Bodily sensations function primarily as a means of guiding therapeutic “improvisation.” (Mattingly, 2000). Through the signs and signals of the bodily “texts,” the specifics of the medical plot are dramatized and filled in. By interpreting the sensations in their body, the “decorative starting points” or “skeletal plots” of their narrative genres are, through therapeutic improvisation, “transformed into a flesh-and-blood event,” and therein lies the “emergent” qualities of Q’eqchi’ medical dramas (Mattingly, 2000, p. 205).

Bodily sensations are also described by Francisco and Emilio to be a form of spiritual knowledge. Beyond the sensations that arise during the therapeutic interaction, they can occur outside a specific healing encounter, away from the patient, to provide additional medical information pertinent to a particular case. “Sometimes I feel some sensations in my body before they [patients] reach to invite me,” Francisco noted, “They [patients] want the sickness to be treated immediately. I sometime get a sensation above my eye or on my lips.” Similarly Emilio related that “if a patient or visitor is coming then this part [lower foot] will shake.” “When you feel the sensation here [lower foot] then you better do your healing job the right way,” Emilio again suggested, “When you go to heal...you’ve already felt the sensation; for me, my *nawal* [maatan] is *kej* and in my foot will shake.”⁵² They [sensations] transmit information. Like I said, when they [patients] will come to me for help, I will sense that.” As *aj iloneleb*’ explained, bodily sensations can also “transmit information” allowing them to appropriately prepare for a patient’s request by collecting healing supplies and making personal arrangements.⁵³ These

⁵² Here Emilio is relating the particular formation of bodily sensations to his *nawal* or *maatan*, that is to *Kej*, the month in the Maya calendar in which he was born. The day in which the healer is born will determine, to a great extent, the particular way in which spiritual energy or bodily sensations are configured. Thus, each bodily sign is unique to a particular healer or spiritual guide which is reflected upon and learnt about during training. We will come back to this point in the next section looking at the body as a site of knowledge. For more detailed information regarding the training of this process see Molesky-Poz (2006).

⁵³ In Q’eqchi’ medicine it is an important principle to be abstaining from sexual relations during the treatment of a patient. Abstinence is thought to increase the power of the healer and effectiveness of any therapeutic intervention. In a sense, it makes them a better channel of the spiritual energy and power that is said to work through them during

bodily sensations that arise prior to contact with a patient are understood to be manifestations of spiritual energy (Molesky-Poz, 2006), where “signs” of the healer’s spirit manifest in their own bodies.

In Q’eqchi’ metaphysiology, the spirit (*muhelej*) of a person is understood to have its own “mind” and agency, thereby being able to take specific courses of action in the material world and communicate to the individual. “If the spirit senses danger,” Francisco mentioned, it will warn or convince the body that some specific action is required. “The spirit is similar to the body,” Francisco explained, “it performs activities as a human does but everything is invisible.” It is through one’s *muhelej* that communication with the panoply of spirits in Q’eqchi’ cosmovision can occur. In this way, the individual spirits of the healers often function as “guides” to appropriate medications in the Maya mountains and can warn the healers when a serious illness may need their attention. This “communication” occurs between the *muhelej* and the healers through the medium of the body, the “lightening in the blood” (Tedlock, 1982, p. 139). Bodily sensations are, from this perspective, related to the knowledge that the *muhelej* may have gathered through dreams, interactions with the spirits of the Mountains and Valleys, or as they go from the body and “see” different events in both past and future. Thus, the bodily sensations also provide a spiritual foresight, prophetic vision, or “empathic in-sight” that provides important sources of medical, individual, social and cosmological knowledge (Groark, 2008).

Aj iloneleb’ also describe a kind of “knowing” through these bodily sensations about details of their patients that are untold or un-narrated. As previously mentioned, it is common during Q’eqchi’ healing encounters for the patients to say little and remain passive participants in

a healing encounter. Bodily sensations that arise prior to contact with a patient can be important insofar as they notify the healer that abstinence will be required, thus allowing the healers to know when they should prepare themselves accordingly.

the healing drama. Thus, unlike the co-construction of the “emergent” therapeutic narrative observed by Mattingly (2000), those healing dramas observed in the current study occurred almost entirely without the conscious participation of the patient. In other words, patients did not actively shape the therapeutic narrative verbally (Harvey, 2008). Indeed, in Serena’s case, save for the brief description involving the medicinal herbs, Emilio and Serena went the entire session in silence. Thus, it is the sensations in the healer’s body that, in a way, act on behalf of the patient, “communicating” and helping to “co-construct” the healing drama.

“At times,” Francisco described, “[if] the patient doesn’t believe that he can get healed then the healer’s legs would get a feeling. When I’m treating it, I feel that they trust me in doing the work. The healer might not come back again the next day because the patient is not cooperating.” Bodily sensations can also, therefore, inform the healer about patient compliance with treatment and whether or not he or she “accepts” that the healers can heal. Q’eqchi’ patients may occasionally not comply with the healer’s medicinal recommendations, perhaps because of scepticism or because of the growing power of biomedicine (Staiano, 1981). Whatever the reason, *aj iloneleb*’ will not continue to treat patients who do not themselves make efforts towards recovery and, at least on some level, “accept” *aj iloneleb*’ expertise. In this way, bodily sensations are a means by which certain inner states of the patient are known by the healers, again a kind of “empathic in-sight” (Groark, 2008). As “signs” and “symbols” that arise in the healer’s body, these sensations can, at times, point beyond themselves to the underlying emotions, feelings, motivations, thoughts or desires of a particular patient.

The bodily sensations that arise in *aj ilonel* during patient interactions, whether in the actual therapeutic encounter or in a separate setting, are an extension of the “social quality of the plot” (Mattingly, 1994). More accurately, what we observe here is a “spiritual quality of the plot”

that is equally as dialogical, improvisational and co-constitutive, yet occurs in the complete absence of the spoken word. In Q'eqchi' clinical interactions, there is a confluence of spirits, blood, and bodies that “communicate,” mesh, and blend together. This “spiritual quality of the plot” situates and “emplots” a case within a broad framework of narrative genres and prognosticates the unfolding medical drama (Mattingly, 1994). It suggests important solutions, situates experiences teleologically, and guides the specific improvisational elements of the therapeutic performance. In this way, bodily sensations are central to the “emergent” properties of Q'eqchi' medical encounters, transforming the abstract general rules of Q'eqchi' narrative genres into “flesh and blood events” (Mattingly, 2000, p. 205).

Embodiment and the Process of “reading”

Having posited that bodily sensations arising in *aj iloneleb*' bodies can act as distinct “texts” to be read and interpreted in Q'eqchi' healing encounters, this final section looks at the process of “reading” and outlines how the body, as a source of experience, knowledge and perception, guides the dialogical “reading” of various Q'eqchi' medical “texts.”

According to Desjarlias (1992), previous ethnographic accounts, largely those from interpretivist positions from around the 1950s onward, reflect a tendency to privilege linguistic, discursive and representational aspects of human experience and knowledge over and above the more visceral and tacit. To a large extent, Desjarlias argued, research in the latter half of the twentieth century in psychological and medical anthropology in general, and ethnography in particular, neglected the realm of the senses and the “embodiedness” of suffering and healing experiences. Desjarlias (1992) exclaimed, “We have lost an understanding of the body as an experiencing, soulful being before and beyond its capacity to house icon and metaphor” (p. 29). Judith Butler's (1993) reflections also come to the foreground here, as she observed that “in

recent years, there have been calls to retrieve the body from what is often characterized as the linguistic idealism of poststructuralism” (p. 14), and that “when the constructivist is construed as a linguistic-idealist, the constructivist refutes the reality of bodies” (p. 10). Similarly, Lock and Scheper-Hughes (1996) observed what they call an “analytic gap” at the centre of discourses regarding human relations and social life: the absence of the body. “Though the body was invoked in previous ethnographic literature,” these authors argued, “it was conceptualized as little more than a passive participant, part of the domain of the natural sciences but attached to a lively, responsive, nomadic mind, the true agent of culture” (p. 42).

As a consequence of this “analytic gap” in much of the early theory and research in psychological anthropology, perception, cognition and human ways of “knowing” are oftentimes divorced from the lived experience of the body, or the “embodiedness” of day-to-day living (Pfeifer & Bongard, 2006; Mattingly, 2010). Following largely after the “body-machine” legacy of Descartes’s dualism, Damasio (1994) and Hass (2008) observed that perception is often theorized to involve a kind of mental representation, a “re-presentation of those extended bodies that are in mechanistic, point-by-point causal relations. It is a copy of that original presentation, a *mimēsis*, with color, depth, texture, size, and shape added by the mind” (Hass, 2008, p. 21). This perspective informs what might be called “traditional” accounts of perception that assume people represent what is “out there” in the world in abstract symbols and language and then think in such a way as to manipulate and alter these abstract signs and symbols (Barsalou, 1999; Michalak, Burg, & Heidenreich, 2012). From here, perception is inherently amodal because it would be the same whether it was done by a computer or by a disembodied brain.

Parallel to this “traditional” or amodal view of perception are alternative positions that recast the body as central to perception, experience and human ways of knowing. The term

“embodiment” has been used by a diverse array of researchers in such fields as psychology (Barsalou, 1999; Glenberg & Robertson, 2000; Kignel, 2012), sociology (Bourdieu, 1977; 1990), philosophy (Clark, 1997; Fuchs & Schlimme, 2009; Merleau-Ponty, 1962), artificial intelligence (Pfeifer & Bongard, 2006), anthropology (Csordas, 1990; 1997; Desjarlias, 1992; Romberg, 2012), and linguistics (Lakoff & Johnson, 1999). In these cases, embodiment is used to express the notion that knowledge and human perception are, to a great extent, based on embodied sensations, grounded in bodily states, and in the brain’s “context-specific” modes of interaction (Niedenthal, 2007).

Laying much of the theoretical groundwork for diverse works in the areas of “embodiment,” French philosopher and phenomenologist Merleau-Ponty (1962) argued that the starting point for understanding perception is the experience of perceiving in all its richness and indeterminacy rather than in phenomenal objects because, in fact, we do not have any objects prior to perception. Rather, as Merleau-Ponty (1962) suggested, “Our perception ends in objects,” (p. 14) which suggests that “objects” observed in the world are always a secondary product of reflective thinking. This is to say, at the basic level of perception, we have no objects and are simply in the world. Building on earlier discussions of mood states, there is what Merleau-Ponty called a “pre-objective” aspect of our bodily engagement with and perception of the world, an engagement that takes place in manners not always “consciously” perceived by the subject. Merleau-Ponty further argued that if perception ends in objects it must begin in the body. For Merleau-Ponty (1962), perception initially takes place, not in an objective and analytical way, but in a bodily, multisensorial way, lacking the language and categories of human experience. The body then become, what Csordas (1994) referred to as the existential grounds of culture and self, the point through which the conditions of consciousness are laid. In

the context of this pre-objective grounding, then, bodies attend to other bodies and “objects” in the world prior to their conscious elaboration as such. Perception can then be viewed as a bodily process of social mediation. Our bodies are not mere receptacles of our intellect; they are “lived” connections, spanning and dissolving difference of subject and object (Merleau-Ponty, 1962).

In addition, many authors have articulated a unique aspect of knowledge attributed to the body and bodily states. Heidegger (1996), for example, devoted a lot of attention to a way of engagement with and being-in-the-world, or the knowledge one has when one is able to deal effectively with objects and equipment in the world. These kinds of absorbed bodily coping skills for Heidegger, like the common use of a hammer, occur on the basis of unconscious cultural rules for dealing with the world; they are “withdrawn” from our conscious thinking and interpretive processes.⁵⁴ This “know-how” for Heidegger, is “the kind of dealing which is closest to us is, as we have shown, not a bare perceptual cognition, but rather the kind of concern that manipulates things and puts them to use and has its own kind of knowledge” (p. 95). Our bodily skills, according to Heidegger, are pre-reflective, pre-representational, and pre-conceptual forms of knowledge; they are part of our “pre-objective” bodily engagement and perception with the world. Along these lines, Polanyi (1966) developed the term “tacit knowledge” to describe the collection of professional or procedural knowledge that, after sufficient practice, experts possess. It is not processed cognitively, but rather lies at a not-quite-conscious level, accessible through acting, judging or performing, that is, through bodily engagement with the world. Like Heidegger’s kind of “know-how” or absorbed coping, Polanyi’s “tacit knowledge” is pre-

⁵⁴ Heidegger (1996) often used the example of a hammer to illustrate this point. When using a hammer over and over a person no longer needs to consciously think about and reflect on the hammer, its position in space or how its being used. Rather, the hammer becomes “withdrawn” from our conscious thought processes and “absorbed” in the background of our particular activity. It is in this way that Heidegger’s (1996) perspectives contrast with the story of mental representations in the “traditional” view of cognition and perception (Clark, 1997; Hass, 2008).

objective and pre-representational, it is that which we naturally perform on the basis of our cultural habituation into a certain mode of bodily engagement.⁵⁵

Following these positions, Pierre Bourdieu (1977) expanded the term of “habitus” to reflect a collection of bodily practices or enduring dispositions which are, to a great extent, “an unconscious, collectively inculcated principle for the generation and structuring of practices and representations” (p. 72). This principle, Bourdieu continued, “is nothing other than the *socially informed body*, with its tastes and distastes, its compulsions and repulsions, with, in a word, all its senses” (p. 124 italics in original). Thus the habitus is a kind of cultural knowledge built up through interaction with the world and held at the level of lived experience, the body. As Bourdieu (1977) further explained,

The habitus is the universalizing mediation which causes an individual agent's practices, without either explicit reason or signifying intent, to be none the less “sensible” and “reasonable.” That part of practices which remains obscure in the eyes of their own producers is the aspect by which they are objectively adjusted to other practices and to the structures of which the principle of their production is itself a product (p. 79).

This notion of habitus reflects a kind of bodily knowledge that is developed from the psychologically internalized content of the behavioural world. It is, as Polanyi, Heidegger and

⁵⁵ This description is reminiscent of “procedural memory” or “muscle memory” in contemporary psychology, that is, a memory for doing things. Procedural memory encodes embodied and practical knowledge about self and world in the form of non-representational patterns of action and motility—Ryle’s (1949) ‘knowledge how.’ Procedural memory guides the performance of many daily activities and most frequently resides below the level of conscious awareness. When needed, procedural memories are automatically retrieved and utilized for the execution of the integrated procedures involved in both cognitive and motor skills; from tying shoes to flying an airplane to reading. In contemporary psychology, procedural memories are accessed and used without the need for conscious control or attention. Procedural memory is a type of long term memory and, more specifically, a type of implicit memory. Procedural memory is created through “procedural learning” or, repeating a complex activity over and over again until we figure out how to make all of the relevant neural systems work together to automatically produce the activity. Implicit procedural learning is essential to the development of any motor skill or cognitive activity. What we argue here, then, is that the Q’eqchi’ healers’ practices of “reading” various “texts” available to them in any particular case, including the means by which to respond or act on the basis of the received information, is a process likened to procedural memory—it is a skill or practice below or “withdrawn” from conscious awareness and that guides much of their healing activities.

Merleau-Ponty suggested, a bodily skill that is pre-presentation, pre-conceptual and pre-objective.

This discussion on the role of the body with regard to knowledge and perception allows us to observe important aspects of *aj iloneleb*' medical practice through a broad paradigm of "embodiment" (Csordas, 1990). During the Q'eqchi' healers' "reading" of various "texts" within a particular case, they come to "know" how the patient is doing, what is needed for his or her recovery, and what factors may have led to his or her condition. As we have seen, this "knowing" does not require the patient to speak and is, it is argued, largely based on a kind of "somatic attention" (Csordas, 1993), or a form of skilled coping or "know how" that operates at the pre-objective level. Knowledge and perception in the context of "reading" a case in Q'eqchi' medicine "is not just a matter of concepts and propositions, but also reaches down into the images, sensorimotor schemas, feelings, qualities, and emotions that constitute our meaningful encounter with our world" (Johnson, 2008, p. xi). Language and narrative, then, is not the sole storehouse of knowledge or conveyer of meaning. Rather, the Q'eqchi' healers long years of attending to patients is largely a somatic practice, a kind of "tacit-knowledge," "know-how," habitus or enduring bodily disposition—an embodied, pre-conceptual and non-propositional type of embodied knowledge and perception.

In Q'eqchi' healing, a treatment encounter almost entirely involves direct contact between the healer and patient, typically through the pulsing of the patient's wrists. In grasping Serena's wrists to "communicate" with the blood or become attuned to sensations within his own body, Emilio is locating her condition within a known taxonomy of disorder and working out the most appropriate treatment regimen. To a great extent, this "locating" or prognostic process is not something one can think through—in the typical linguistic sense—rather, it must be sensed, a

manner of thinking through or with one's body.⁵⁶ As Hinojosa (2002) observed in the practice of Maya bone-setting in the highlands of Guatemala, Q'eqchi' healers and patients observed in southern Belize attend to each other's bodies. This kind of "empathetic intercorporeality" (Harvey, 2006, p. 909) becomes the starting point of perception in Q'eqchi' medicine, and an important source of knowledge into the patients' conditions.

During the process of "reading" a particular text, the bodily knowledge of the Q'eqchi' healer moves and responds to the diagnostic and prognostic information acquired. This is a form of engagement that occurs largely on a pre-objective and pre-conceptual level. They simply do what they need to do or what any good healer would do. As Augustino explained,

When you're healing if you find out the person is suffering with that [*rahil ch'ool*] your body will shake and feel a little pain too in the same area and it tells you that yes the person is suffering from this. Same thing with the headaches, when you hold the pulse your body will jerk and pain, and that gives you a little hint as to what he's suffering from. When you hold somebody you'll find out chills will come to your body and right away you'll know the person is not comfortable and is suffering some of those things.

When I start to work on sick people I try to set myself into the shoe of that person. Like hear [and] experience what you're going through and based on that I try to figure out what sickness you're going through. Sometimes they might not tell you or can't explain and through the spirit I'll get it. It just came automatically [to me]. It's God's inspiration I think. It just come to me like that. When I heal it comes automatically, it helps a lot.

⁵⁶ This also explains why the Q'eqchi' healers, to a great extent, have difficulty portraying their knowledge in explicit, representational ways as evoked during the process of formal interviews. Their knowledge is primarily at a pre-objective and pre-conceptual level in their bodily dispositions and way of being-in-the-world. Learning to become a Q'eqchi' healer is primarily a process of "doing" and being engaged in the world as opposed to semantic or cognitive based learning in much of Western approaches.

This notion that medical knowledge or a patient diagnosis came “automatically” to the Q’eqchi’ healers is a common theme of their work. As Flemming and Mattingly (2008) observed in Western clinical contexts, “Clinicians often literally act before they think. This is not mindless action, it is an automaticity of expertise which does not have to be processed through the lengthier channels of formal cognition” (p. 57).⁵⁷ This “automaticity of expertise” reflects Augustino’s remarks that patient knowledge “just came automatically,” a form of perception and action based on a bodily engagement with the world and “absorbed coping.” Since this form of know-how is, as Heidegger suggested, “the kind of dealing which is closest to us,” it becomes “withdrawn” for the Q’eqchi’ healers and seems, to the conscious mind, to come “automatically.” As Flemming and Mattingly (2008) observed, some of the Q’eqchi’ healers in this study literally acted before they thought. They engaged with their patients on the basis of bodily perception and knowledge, a habitual disposition for dealing with the world built up or based on previous cultural knowledge (i.e., their narrative genres) and understandings of cosmovision.

From this perceptive, Bourdieu’s (1977) concept of the habitus is akin to a kind of practical or “narrative” reasoning understood in its cultural context. It is a kind of “automatic” and contingent form of knowing that some might label “intuition” (Montgomery, 2006). When applied in clinical situations, the automatic processes of bodily habitus become “withdrawn” and invisible, and, like the procedural memory involved in riding a bike or driving a car, it is “just known.” As Augustino described above, the Q’eqchi’ healers in their treatment of a specific case, “see” and respond “automatically,” an embodied knowledge that erases itself and becomes

⁵⁷ This concept of automaticity deepens our understanding of previous discussion regarding the processes of diagnosis through pulsing or reading the prayers. In Chapter Four it was argued that pulsing is a dialogical process of communicating with the patient’s blood and waiting to “read” or hear the “speaking” of the blood. What we see here is that this entire process occurs largely through “withdrawn” embodied forms of engagement or procedural memory and not necessarily through abstract representations.

invisible. Indeed, in his treatment of Serena, Emilio simply did what any good healer would do. In this way, habitus is the healers' cultural predispositions to perceive, know or act in a given situation (Bourdieu, 1977); an unreflective, pre-conceptual and pre-objective way of bodily engaging with the world. Thus "narrative reasoning" is, in part, an embodied process.

This invisible and "automatic" aspect of Q'eqchi' healing relates to another important aspect of their cosmovision. For the Q'eqchi' healers, it is common to attribute knowledge that arises in unreflective, "automatic" or pre-conceptual ways to the realm of the spirits. As Augustino importantly remarked in the previously cited quotation, "Sometimes they [patients] might not tell you or can't explain, and through the spirit I'll get it." The invocation of "spirit" here, as previously discussed regarding the concept of moods, relates to a kind of "otherness." It is an attribution to the spiritual realms regarding aspects of their medical practice that come "automatically" or in a "pre-objective" manner (Merleau-Ponty, 1962). The Q'eqchi' healers often note that during therapeutic encounters their hands move on their own accord, or that they are receptacles or servants of a "higher power" or "divine wisdom" that is working in and through them to perform their healing practice. Since the source of the Q'eqchi' healers' somatic-based intuitive knowledge is indeterminate and largely outside conscious knowledge, it is both natural and rational to locate this "tacit knowledge" in the realm of the "spirits." For the Q'eqchi' healers, bodily engagement with the world and intuitive knowing can involve an other-than-human realm insofar as this knowledge is not easily available to conscious thought. At the experiential level, the Q'eqchi' healers' bodily engagement is "withdrawn" and invisible. It is felt to possess its own form of agency, informing and guiding the body as to what it ought to do next in a given situation. The "spirits" in this context, as well as during notions of mood states discussed earlier, are in many instances the locus of explanation and agency insofar as "spirits,"

like the embodied forms of perception and knowledge, are invisible and “withdrawn” from everyday life and social interaction.⁵⁸

Before concluding this section one final point warrants reflection regarding the process of what might be called “empathy” in clinical interactions. Again looking to Augustino’s quote cited above, an interesting positioning of the healer in an empathic-like process is observed. Augustino’s efforts to feel the suffering of the patient represent a kind of empathic process or even a form of “radical empathy” (Koss-Chioino, 2007, p. 664). Empathy is generally understood as an imaginative projection of an internal or subjective state into an object in such a way that the object appears to be infused by it or, more simply, the capacity for mutually participating in another’s feelings, thoughts, or ideas (Hollan & Throop, 2008). In early clinical psychology, Carl Rogers (1959) suggested that “the state of being empathic meant to perceive the internal frame of reference of another with accuracy . . . as if one were the other person, but without ever losing the “as if” condition” (p. 210). Similarly, Kirmayer (2008) argued that “to empathize is to understand another’s experience through feeling or thinking something similar oneself. Empathy reflects the willingness to meet, engage, and be moved by the other—whether that other is an aesthetic object or a person” (p. 458). In a related manner, Koss-Chioino (2007) observed that “empathy, especially radical empathy, offers an experience of human commonality through thinking and feeling into the minds and bodies of others in order to assist them to heal”

⁵⁸ In no way do we intend to merely reduce Q’eqchi’ conceptions of the spiritual world to bodily dispositions at the pre-reflective or pre-objective level. This seems to be the clear direction that Csordas (1990) and others have gone wherein he argued that “Certain preobjective phenomena are misrecognized as originating in God instead of in the socially informed body” (p. 33). We do not wish to go this far and seemingly reduce, as Durkheim did for his conception of society, the entire realm of spiritual reality or the sacred to a material conceptualization of “withdrawn” bodily dispositions. We suggest this urge to reduce the spiritual world by way of material explanations is part of a materialist legacy of western science and biomedical practice that needs to be critically engaged in future years (Medina, 2006). Since adopting Indigenous epistemologies, we leave open the possibilities of an ontological realm of spirits, spiritual forces or ancestors that may act on human realities in unknown ways. What we hope to bring to the center of this discussion is rather the healer’s way of bodily engagement with the world and how this may account for some, but not all, of their invocations regarding the “spirits” in their medical practice.

(p. 664). In this way, empathy can be understood as having a cognitive component as in taking on the perspective of the other, an emotional component as in connecting, resonating or attuning to feelings, or a bodily component of another in terms of bodily stance, gesture, or habitus (Kirmayer, 2008, p. 458).

To accurately and appropriately empathize with patients is not an easy process. Kirmayer (2008) noted that developing an empathic understanding in clinical encounters often requires the correct kind of “mental furnishings” (p. 465), and that the ability to correctly read and interpret certain thoughts, gestures, words, or emotional expressions is based on a shared understanding of cultural orientation—generally termed “cultural competence.” There are many social and cultural barriers to empathy in clinical encounters, for example: different language; differences in the use and meaning of gestures; facial or emotional expression; or differences in the cultural assumptions of reality. Thus, little of the information that Kirmayer (2008) suggested is “needed for accurate empathy” may be explicitly given by patients, “not because of any lack of expressive skill or openness in communication, but because so much of it is tacit, procedural knowledge or else located in larger social and historical contexts” (p. 466). Thus, if relying solely on cognitive or emotional components of empathy, a healer’s ability to empathize with a patient’s internal state can often be frustrated.

The Q’eqchi’ healer’s ability to “read” the pulse and sensations in their own body cuts through the social projections a person may or may not display, including narrative accounts of experience or physiological symptoms. In some sense, then, a patient’s emotions or story told are irrelevant in a Q’eqchi’ healing encounter, for the body knows and the blood speaks (Hinojosa, 2002). Through their pulsing activities and interpretations of their own bodily sensations, the Q’eqchi’ healers emulate a “bodily empathy” (Hinojosa, 2002) or “radical empathy” (Koss-

Chioino, 2007), an empathic process that transcends what Kirmayer (2008) suggested are the “mental furnishings” required to empathically engage the other (p. 465). Indeed, the Q’eqchi’ healers have no problem treating those who are not Q’eqchi’ in cultural background and practice, as Augustino remarks, they can “place themselves in the shoes of the other” nonetheless. From here it is argued that this kind of “empathetic intercorporeality” (Harvey, 2006, p. 909) or “radical empathy” (Koss-Chioino, 2007) is more related to a kind of “in-sight” that can be observed in the “reading” of various “texts” in Q’eqchi’ medical practice (Groark, 2008). The sensations in the healer’s body and the pulsing activities are primarily a means by which *aj iloneleb’* come to “know” the inner states of others; it is a “dynamic and active process of “seeing within,” through which one attempts to gain access to, and understanding of, otherwise occluded cognitive states—particularly those dimensions of self that are actively hidden from view” (Groark, 2008, p. 429). In this sense, then, the medical gaze of the Q’eqchi’ healers can, on occasion, go deeper to the inner states and desires of the patient, while also looking beyond the confines of the body into the social and cosmological space—a “spiritual quality of the plot.” As Groark (2008) observed, and as seen in the current study, Q’eqchi’ *aj ilonel* “see” within and empathically “know” the internal states of a patient through the pulsing of the blood, their bodily perception, interpretation, and a kind of narrative reasoning that centers on somatic modes of apperception. By conceptualizing empathy as a process of bodily engagement at the pre-objective level, a perspective of empathy that is not necessarily dependent on, nor frustrated by, the overtly cognitive processes or “mental furnishings” outlined in previous literature is developed (Kirmayer, 2008).

Overall, the observations with Q’eqchi’ healers suggest that bodily ways of knowing and “somatic attention” are central to the “reading” of various “texts” in Q’eqchi’ medicine (Csordas,

1993). The process of dialogically “reading” a text is so natural and automatic for the *aj iloneleb*’ that it becomes “withdrawn” and unreflective, part of their “absorbed coping” and skilful dealing with the world (Heidegger, 1996). Due to the indeterminacy of these bodily modes of apperception, this kind of “withdrawn” mode of engaging with the world is understood and experienced by the Q’eqchi’ healers as a kind of “otherness,” thereby naturally finding its place among the realm of agentic spirits and cosmic forces. In this way, clinical competence in Q’eqchi’ medical practice is not so much about cognitively “knowing” a patient’s historical or cultural perspective, nor is it even about sharing a common language. Rather, it is about how a healer can automatically and somatically attend to particular conditions based on a process of dialogical “reading” between the emergent properties of a case, their narrative genres of mental disorder, and local understandings of cosmovision.

Chapter Conclusions

This chapter began by reflecting on the relation between embodiment and narrative in healing encounters, that is, on “life as lived” or embodied experience, on the one hand, and “life as told” through narrative discourse, on the other (Bruner, 1984). By building on Mattingly’s (2000) insights regarding the nature of “emergent narratives,” the preceding analysis demonstrates, through a broad paradigm of embodiment (Csordas, 1990), how the Q’eqchi’ healers’ generalized narrative genres are, in actual clinical time, both improvised and embodied. Thus, far from being a canonized cultural script that directs healing performances, narrative genres are improvisational and embodied stories.

Not all of the healers demonstrate the ability to “read” a bodily “text” in the same way. As such, a hierarchy of knowledge similar to the continuum of consensus developed in Chapter Three is observed. For the Q’eqchi’ healers who have developed this ability through years of

practice, the improvisation of Q'eqchi' medical dramas often occurs in ways that are related to an "automaticity of expertise" (Flemming & Mattingly, 2008) where the healers literally act in "automatic" and embodied ways before they think. Narrative genres and Q'eqchi' cosmovision, therefore, play out and manifest for *aj iloneleb'* at the level of habitus and bodily dispositions (Bourdieu, 1977). A healer's body can carry certain dispositions toward a repertoire of plots that are enacted through the reading of "texts" that emerge in a particular case. Q'eqchi' healers can move in particular ways during healing encounters in order to "further the plot" of an illness condition based on a bodily way of knowing and perception. This is a kind of "tacit-knowledge" of the "complex repertoire of cultural resources" providing starting points for the performative improvisation during therapeutic encounters (Mattingly, 2000, p. 205). As Mattingly (2000) observed regarding the "emergent" properties of therapeutic encounters,

The narrative moments described are likely to be created with few words; language is not the prime messenger of the story. Like any ritual, the healing encounters observed depend on a range of communicative media, especially kinaesthetic ones (p. 189).

Performance and practice in Q'eqchi' medical interactions are thus informed by narrative genres, but again, not as a script that is played out and re-presented in one's mind, but at the level of embodied perception and direct engagement with the world (Merleau-Ponty, 1962).

Moving beyond this context, as we narrate and tell the happenings of our lives, as the healers do for the stories of medical cases they observe, the plots become part of our habitus and daily dispositions or engagement with the world. Narratives of "life as told" become "withdrawn" and inform our "life as lived." Narratives are felt, embodied and known. Thus, there is a deep connection between narrative and embodiment, a connection that occurs at the experiential immediacy of the lived body.

CHAPTER VI: Spirit “attacks” and a “new” disease

Early Saturday morning we met Emilio and Francisco for our planned two-hour trek into the mountains to conduct a healing ceremony. Our plans, however, suddenly changed. When we arrived at Francisco’s home, he and Emilio were visibly distraught. Standing with an unrecognized man, they explained that the man’s son, Domingo, had collapsed into unconsciousness while harvesting beans on their farm near Jalacte and was rushed to the Punta Gorda hospital. Without much discussion our research team and the Q’eqchi’ healers piled into the truck and drove to the hospital. Despite a long line-up at the Emergency Centre of the hospital, our group passed through and went up the stairs to Domingo’s hospital room. Upon entering the sterile, six-bed room, it was obvious that Domingo was seriously ill; he hardly moved and seemed catatonic. His arms were strapped into the hospital bed and a small bag of clear intravenous fluid dripped into his right arm. His bones seemed to protrude through his thinly stretched skin and only small bursts of grunting noises whispered from his foam-covered lips. According to the patient’s father, and from the discussions between Emilio and Francisco, Domingo suffered from a severe type of epilepsy or *eet aj yajel*, which the *aj iloneleb*’ refer to as *rilom tzuul*, a genre of spirit “attack” translating as “illness of the Mountain Spirit.” Treating the situation with care and concern, and oblivious of the hospital setting, Francisco rolled up his sleeves and speedily began his healing work.

While Domingo lay motionless on the hospital bed, Francisco readied herbal medications that were prepared in advance of the trip to the hospital. Francisco poured a small amount of the medicine onto Domingo’s head and then into the small cap of a plastic water bottle. He fed the liquid slowly and carefully to his patient. Domingo’s parents stood beside the hospital bed watching Francisco intently. After two small capfuls of medicine, Domingo’s disposition

changed little; he continued to lie on the bed moving his legs and arms only slightly. Francisco then began to pour the medicine onto his hands and wipe it onto Domingo's head and chest, the excess dripping onto the hospital bed and sheets.

Having been engaged in conversations outside, Emilio entered the room and stood at the foot of the hospital bed, observing his brother and their patient with a focused and compassionate glance. Domingo's father and mother remained nearby while Francisco continued his work. After soaking Domingo's head and chest in the medication, Francisco provided more medication for Domingo to ingest. Emilio encouraged Domingo to drink the liquid as he seemed to be resisting. With a shaking left hand that was tied to the bed and a few vocal outbursts and coughs, Domingo eventually managed to consume two more capfuls of the herbal medicine. Emilio continued to offer words of encouragement to the boy. Francisco repeated the patting motion on Domingo's head, again applying more medication.

Following the administration of medicinal herbs, Francisco reached into his healing sack and removed a dark plastic bag filled with the remains of a duck that was killed earlier that morning. Francisco moved the bag over and across Domingo's entire body. This is a common medical procedure referred to as *awas*, meaning "feeding the spirit of the illness" or "taking out the spirit of the illness." As Francisco did this, he also began to pray quietly. The *awas* process was delicate and treated with cautious respect, as both Domingo's parents and Emilio took a large step back as Francisco began moving the bag over his patient's body. As the bag glided a few centimetres above his skin, Domingo remained motionless, save the movements of his left arm still strapped to the hospital bed and his long, grunting breaths.

After several moments of this process, Francisco and Emilio said good-bye to Domingo's parents and swiftly left the Punt Gorda hospital. While leaving the building, Francisco carried the

plastic bag with duck remains slightly in front of him, as if the contents were dangerous if they came too close. He continued across the street from the hospital, past the conveniently placed cemetery to the ocean which was only about twenty meters away. Here Francisco offered some words of prayer before he quickly threw the black plastic bag down the steep slope to the water below. Francisco clearly wanted to dispose of the bag quickly, safely and quietly. Francisco then returned to the road and met Emilio, who was waiting for his brother with a bottle of rum. The rum was not for consumption; rather, Emilio carefully poured it over Francisco's hands, as is commonly seen in Q'eqchi' washing before and after meals. Again, the two brothers were clearly concerned with the contents of the bag somehow contaminating them. The alcohol, in this case, was for cleansing and protection.

The healing session in the hospital, including the disposal of the plastic bag and its contents, lasted about fifteen minutes. We were not aware at the time that this occasion was to mark the beginning of a several-month-long healing process with Domingo and his family, a healing journey with several surprising turns of events in the plot and narrative.

Narratives of Spirit “attack”

Once contacted by Domingo's parents, Emilio and Francisco began, fluidly and naturally, the process of “emplotting” or “domesticating” his illness experience within the narrative genres of mental illness and disease with which they are familiar (Becker, 1997; Mattingly, 1994). Through their process of “narrative reasoning” *aj iloneleb* 'ask what narrative genre Domingo's case may reflect and imaginatively engage in making sense of the unfolding medical drama (Good, 1994; Flemming & Mattingly, 2008). It is the interpretation, perception and construction of the illness narrative and plot which give order to the patient's story and direct the therapeutic

encounter; that is, how the “sequential ordering of events and the relations that connect them to one another” are conceptualized and understood (Good, 1994, p. 145).

More than frames of sequential or temporal relations, Good (1994) described, “plot is the meaningful order through which experiences and events are joined together to make a story. We might think of plot as the logic or perhaps the syntax of a certain kind of discourse, one that develops its propositions only through temporal sequence and progression” (p. 145). Thus, the diagnosis of Domingo’s condition is part of an ongoing process of “emplotment,” one that is somewhat fluid and improvised based on the emergent properties that arise amidst his various treatment encounters and which are seen as “acts of creative retrospection in which meaning is ascribed to the happening and the parts of the experience” (Turner, 1982, p. 17).

Domingo’s illness narrative began several weeks prior to the incident which led his family to take him to the Punta Gorda hospital. It was the peak of the harvest in southern Belize and most families living in Jalacte village were out in their corn or bean fields for long hours each day in the unrelenting Central American sun. One afternoon, while harvesting, Domingo suddenly felt weak and became momentarily unconscious, falling to the ground while shaking his limbs for several minutes. Domingo’s father quickly attended to his son who soon regained consciousness and strength while he rested at their home the following day. A momentary bout of exhaustion or overheating was suspected. It was nearly two weeks later when, again out in the fields, a second incident occurred, this time more severe. Domingo had fallen to the ground, but this time did not regain consciousness and also appeared to be foaming at the mouth. His father, with the help of neighbours, brought Domingo back to the family home in Jalacte. Breathing softly but steadily, Domingo remained unconscious. The family was severely worried and decided to rush their eldest son to the Punta Gorda hospital two hours away. During the trip,

Domingo regained consciousness only momentarily, visibly agitated and weak, while his skin and complexion darkened. Domingo's parents eventually arrived in Punta Gorda late Friday evening. While Domingo's mother waited with her son at the hospital, his father immediately went to Francisco's Punta Gorda home to seek his assistance. Early Saturday morning, the research team picked up Domingo's father, Emilio and Francisco and drove to the Punta Gorda hospital to check on Domingo's frightening condition.

Through the discussions that occurred between Emilio, Francisco and Domingo's father late Friday evening and into the early morning on Saturday, Emilio and Francisco came to "emplot" and diagnose Domingo's case within the spirit "attack" narrative genre, as a form of *rilom tzuul*. As explored in Chapter Three, this narrative genre primarily involves the inciting incident of "contact" with an "evil" spirit. There are two concepts that are central within spirit "attack" conditions that underlie the logic of its diagnosis and treatment. The first involves a force or entity that is present with the individual that was neither there to begin with nor part of the natural state of being-in-the-world. This is typified in *aj iloneleb*' discourse regarding the intrusion of an "evil" spirit that has not only "attacked" the individual, but has remained within, continuing to cause harm and illness. In this way, the "evil" spirit is described as "feeding" on the patient which persists until a "payment" is properly made to the Valleys and Mountains, the keepers of social and moral order.⁵⁹

⁵⁹ Although this discussion follows a similar logic as compared with the "illness agency of affect" discussed in the contexts of mood disorders and "Thinking too much" genres presented in Chapter Five, there are important distinctions between how these "evil spirits" are conceptualized and described. First, the cause of "evil spirits" impacting or influencing an individual regarding "Thinking too much" conditions is the act of thinking too much or dwelling on some form of social misfortune. In Spirit "attack" genres the cause is typically a form of moral, cosmological or spiritual transgression against the normal social order. Thus, in these conditions "attack" is rapid and instantly debilitating as opposed to slow and subtle for "Thinking too much" genres and especially mood conditions like *rahil ch'ool*. In Spirit "attack" genres there are also strong notions of "permission" and "payment" that are brought to bear on the illness narrative which places the spirits of the Mountains and Valleys as the central actors. This discourse does not occur in the same way when discussing mood states that act like "spirits" and come over and envelope a person without their control. See Chapter Five for more details.

The second important notion in this narrative genre is the relation to morality, that the “attack” was provoked by some kind of moral infringement and is a punishment from *Qaawa*’ and the spirits of the Mountains and Valleys. As described in Chapter Three, the individual who is “attacked” most likely did not properly request “permission” from the spirits of the Valleys and Mountains, and thus did not follow the traditional moral and social code that abounds amidst Q’eqchi’ communities. Relationships must be fostered with the other-than-human realm; otherwise illness and sudden attack or punishment are likely to occur, which causes the typical symptoms described above. Thus, it is through a general notion of a Q’eqchi’ moral economy of permission that the narrative genre of spirit “attack” generally, and conditions like *eet aj yahel* or *rilom tzuul* particularly, can be appropriately understood and interpreted. It is also attention to these notions that distinguish spirit “attack” conditions from other invocations of “evil spirits” discussed previously.

These notions of morality and external forces influencing and “attacking” the individual are reminiscent of what Douglas (1966) outlined as the concept of “pollution.” In her book “Purity and Danger,” Douglas (1966) described the force of pollution as something that arises when rules are broken, when proper order and relationships are not maintained within the community, or because cultural categories assumed to be separate are mixed and contaminated. According to Douglas, pollution powers can punish individuals for the symbolic or actual breaking of that which should be maintained within a community and, generally speaking, is devoid of anthropomorphic agents. Like the naturally understood laws of the universe, forces of pollution are anonymous and neutral. Pollution occurs not so much as sins against persons—as is often the case in discourses of witchcraft—but as automatic or naturalistic responses when an

individual disregards the natural social and moral order, a “moral causal ontology” (Shweder, 2003) or a moral economy of permission in the current Q’eqchi’ contexts.

Although engendering a more anthropomorphic discourse than Douglas originally suggested, there are many similarities between this notion of “pollution” and the Q’eqchi’ genre of spirit “attacks.” Seen in this way, *rilom tzuul*, and the other conditions that fall within this narrative genre are a means of expressing concern for aspects of social and moral life which are threatening essential societal and cultural values. Spirit “attacks” give rise to a narrative structure about categories and principles, especially proper relationships, that should be respected. If this respect and “proper” moral course of action is not followed, a force of pollution, which, in our observations is largely conceptualized as the spirits of the Mountains and Valleys or, at other times, as “evil” spirits, will “attack” or “punish” the individual with misfortune, illness or distress. Thus, underlying discourses of spirit “attack” illnesses are expressions of cosmic and social order, about a moral way of being-in-the-world, and about respecting the forces that inhabit our world which are greater than and enveloping the human realm. The treatment of these cases, then, involves a central notion of *awas*, a gift or payment [*toj*] to the spiritual world that brings the moral infringement back to a normal state, to re-establish order. The attack episode and experience of pollution often educates and assists the individual who, through various *mayejak* and healing encounters, gains insight into Q’eqchi’ societal and cultural values that engender positive relations with *Qaawa’* and the Valley and Mountain spirits.

This kind of cultural logic “emplots” Domingo’s case as a form of *rilom tzuul*. The Q’eqchi’ healers suspect that Domingo has done something to offend the spiritual realm and has not properly sought permission from the spirits of the Mountains and Valleys. Domingo’s symptoms frame the story as an “attack,” of not following the normal social order. In addition to

the herbal medications for symptoms, the healers offer a duck to the spirit of the illness that is “polluting” Domingo’s body (i.e., *awas*). This case seems simple and straightforward: the Q’eqchi’ healers were sought for the expertise, a diagnosis or emplotment of the case was made and a treatment regimen commenced. Domingo’s case, however, turns out to be less than straightforward.

After several months of treatment, Domingo’s case did not improve. New elements emerged and the healers shifted their diagnosis throughout the various therapeutic encounters. This chapter details the process that occurs when a case of illness does not fit easily within a single narrative genre, when there are disruptions in the overall illness trajectory. What happens if the treatment and recovery process are more complicated? How do *aj iloneleb*’ shift between different diagnoses, and what processes or narrative strategies do they employ to make sense of this? How do the healers respond to novel details that emerge within a medical case? And what happens if what appears to be a “new disease” unexpectedly arrives in the form of a patient? How does the existing traditional treatment system react? A review of Domingo’s case sheds light on some of these questions and the broader issues of narrative reasoning, emplotment and the structure of narrative genres within Q’eqchi’ medical practice.

Case Study: The story of Domingo

After the first treatment encounter, Francisco returned to the hospital later that same evening to check on Domingo. The six-bed hospital room now housed two patients: a man with a sore arm and Domingo, whose parents were at Francisco’s home resting. Despite the other patient and the hospital setting, Francisco began attending to his patient in a manner similar to previous treatment encounters observed in Q’eqchi’ homes. Francisco did, however, seem sensitive to the hospital setting, as he moved swiftly to avoid confrontations with a nurse or

doctor who may object to the additional treatment he was providing for Domingo. This kind of subtle avoidance between the “traditional” and biomedical systems was a common occurrence in Belize, especially in the southern region of Toledo (Killion, & Cayetano, 2009; Staiano, 1981; Waldram, Cal, & Maquin, 2009).

Francisco searched the room for a container in which to mix the medicinal plants he brought in his healing sack. An old water bottle located under the hospital room sink seemed to do the job. Using water from the tap to fill the bottle half-way, Francisco shredded and mixed the medicinal herbs, placed them in the water, and blended them into a murky green liquid. Once satisfied, Francisco then started, as before, to feed Domingo some of the liquid from the cap of the water bottle. Domingo remain motionless on the bed, grunting occasionally, alternatively opening and closing his eyes. About three capfuls of medicine were given to Domingo, while Francisco offered tender words of encouragement. Francisco smiled affectionately, like a loving father to a helpless child, as he gave the medicine in tiny capfuls to his patient. Following this, Francisco poured some medicine onto his hands and rubbed it on and around Domingo’s head and chest. Pleased with this, Francisco put the lid back on the medicinal water bottle and placed it on the bedside table.

Instead of leaving after what appeared to be the end of the treatment, Francisco lingered bedside for 15 minutes talking with Domingo. By this time Domingo seemed to be doing better; he was awake and could comprehend Francisco’s words. Francisco continued talking with him softly, while holding his patient’s hand. Francisco and Domingo exchanged jokes and they started laughing quietly together. Francisco remained attentive to his patient a moment longer, and then proceeded home.

Over the next three days, Francisco continued to treat Domingo in the hospital with a combination of standard Q'eqchi' healing practices—herbal medications, traditional healing prayers, and the *awas* procedure. Domingo's condition improved slightly and, four days after the first visit, his father requested that the hospital staff allow his son to leave in order to continue treatment at Francisco's nearby home. Much of Domingo's strength had returned as he was able to get up from the hospital bed and move himself into a wheel chair to exit the hospital. His parents were delighted to see this development and hopes remained high for a full recovery.

We drove to Francisco's home where Francisco carried Domingo from the car to a hammock in his yard and set him down. Domingo's body was embraced by the hammock outside Francisco's family home and he seemed to feel more relaxed in this setting as compared to the sterile hospital room. Immediately after Domingo settled into the hammock, Francisco placed his hands on Domingo's head and began uttering his prayers. While grasping Domingo's wrists and softly uttering his prayers, Francisco was pulsing, listening to the blood, "speaking" to the pulse and the spirit of Domingo to assess his condition.

"It just started off with *kaanil* (fright), and they [the patient and his family] let it go until it got serious," Francisco explained during a later interview, "It got serious after a month and that time it turned to *eet aj yajel* (epilepsy) and later turned to the more serious one which is *rilom tzuul* (sickness caused by mountain spirit)." Domingo's first illness symptoms, then, are attributed to a case of *kaanil*. It was thought Domingo was frightened one day while working the fields or walking by a river and was never properly treated. This initial "fright" episode left him vulnerable, like a weakened immune system, to the later conditions of spirit "attack." Francisco thus proceeded at his home to treat Domingo for his current case of *rilom tzuul*.

After grasping Domingo's wrists, Francisco then moved to feel the pulse at Domingo's forehead. With eyes closed, Francisco's hands remained on Domingo's head for a short time while he continued praying. Francisco then moved his hands over and across Domingo's head and body and down to his chest twice, performing the *jilok* or spiritual massage. Stopping on his chest, Francisco placed both hands upon the boy, bowed his head, and continued his prayers. Domingo was breathing heavily and remained motionless on the hammock. Repeating the *jilok* motion several times, Francisco then took hold of Domingo's wrists and once again continued his prayers. "In the prayer, I'm talking to the power of God," Francisco later explained, "or the power of the Valleys and Mountains. They have high power over the earth and I borrow them to put down the heat of the sickness."

This process ended as Francisco bent down and picked up a water bottle full of green medicinal liquid prepared earlier that day. Domingo understood Francisco's instructions and took the bottle and drank the medicine. Domingo finished about one-third of the liquid when Francisco said "*Bueno*" and then placed the bottle on the ground behind Domingo. As he lay on the hammock, Domingo smacked his lips together from the bitter taste of the medicine. At this point our research team was able to ask him a few questions about his condition.

"I was attacked and I feel like I don't know," Domingo explained. While in the middle of harvesting beans he remarked that his head suddenly felt as if it "was going up and down, going up and down."

"Just in the middle of while you were harvesting?" I questioned further.

"Yes," Domingo replied.

"And you don't know why it happened?" I probed again.

"No."

“And then your parents brought you here to the hospital?” I continued.

“Yes,” he said while moving his left arm on his head, “but I don’t know when they brought me”

“Well we’re glad you’re feeling better now,” I gently responded, not trying to push the conversation too far.

“Thanks God yes,” Domingo replied while holding his chest.

Later that same evening around midnight Francisco planned to perform an *awas* ceremony for Domingo, to extract the spirit of the illness through the sacrificial offering of an animal, in this case a duck. We arrived at Francisco’s humble home approximately 30 minutes before midnight and found Francisco seated in a green plastic lawn chair beside Domingo who lay in the same hammock as earlier that afternoon. In the dark of night, Francisco’s figure assumed a prayerful position, one hand on his forehead, slightly bent over, with his other hand over his knees gasping onto the top of a large white bag used for collecting corn or beans in the fields. Francisco remained in prayer for nearly two minutes while Domingo, barely visible, remained in the hammock with legs sprawled out over the edges.

Francisco then opened the large white bag and put his hand inside. Immediately, loud screeching sounds pierced the quiet night. The bag began to move. Francisco kept a calm, stern face. After a few seconds, Francisco slowly pulled his hand from the bag while the screeching continued. In his grasp was a large, white duck flapping its wings hysterically as it hung upside-down while Francisco held its legs. Eventually the duck calmed and its wings stilled. Francisco continued his prayers while holding the duck in his left hand. Francisco later explained that “That’s the way it is, with epilepsy (*eet aj yahel*) and *rilom tzuul*. That’s the way we know that, that’s what to give that sickness, the duck.”

After a minute or so, Francisco stood and moved a step closer to Domingo who remained calm in the hammock. Domingo's parents watched on from several meters away. With his right hand holding the head and his left hand holding the feet, Francisco moved the duck, chest down, over and across Domingo's body. He started at the head and moved the duck across the body several times; at places he touched Domingo with the belly of the duck, at others he remained about an inch above Domingo's exposed skin and clothes. His prayers continued. "I was doing the *jilok*," Francisco later describes, "to tell the sickness that it has done enough and to stop disturbing the body and spirit." The *jilok* in this case was being done with the duck in hand, bringing the duck in close contact with Domingo and his spirit.

After four repetitions with the duck across Domingo's body, Francisco moved about ten steps away and slowly stretched the neck of the duck until it was dead. Domingo and his parents watched with little emotional expression or change in disposition. The duck's wings flapped for several minutes as the nervous system slowly shut down. Francisco then came back to Domingo, while the duck's wings flapped slowly, and continued the *jilok* movements over and across Domingo's body for several more minutes while he continued uttering his healing prayers.

Satisfied with this process, Francisco then placed the duck, wings still moving slowly, back into the white bag. He secured the bag and resumed his prayers. With the entire bag, Francisco stood once more and began moving the bag rhythmically over and across Domingo's body, as in the first healing encounter in the Punta Gorda hospital. After four movements of the large white bag, Francisco signalled that it was time to dispose of the bag and bird. We piled into the truck and headed off to properly offer the duck to the Mountains and Valleys.

This process of *awas* is central to the spirit “attack” narrative genre and is observed in several different forms of contemporary Q’eqchi’ medicine. As previously argued regarding the healing prayers, *jilok*, burning of *copal pom*, and consumption of medicinal herbs, the *awas* ceremonial procedure is an additional healing “text” that is woven into the medical drama to elicit hoped-for endings. “The *awas* works for a sickness that a person is suffering from,” Francisco explained, “the *awas* is used to replace that person to the sickness so those evil spirits will see the replacement belongs to them. It’s like a change or payment [*toj*].”

It is difficult to translate the Q’eqchi’ term *awas*. Often, the translators employed throughout this project used multiple terms or phrases in combination, the most common of which were: sacrifice, replacement, ransom, offering, exchange, and payment. Several phrases are also used to communicate this aspect of Q’eqchi’ medicine, such as “taking out the days” of the sickness, “taking out the scent” of the sickness, removing the “pain” of the condition, or to “lure away” the “evil spirit” of the illness. As Francisco further described regarding the offering of the duck during Domingo’s *awas* ceremony,

When I use it alive I’m telling the Mountains and Valleys that it is a replacement of the patient on what he has done and what is happening to them. We pray over it when it’s still alive. We will give the duck as payment [*toj*] to them, that’s why we use it alive.

When I kill it then I give it to the sickness. We’ll tell them its enough of what they’ve done and they should leave.

As outlined regarding Q’eqchi’ mood states in Chapter Four, illness is often conceptualized to have a generalized agency of affect. The spirit of the illness is understood to “feed” off the patient making him or her weak and display the symptoms of the condition. As opposed to descriptions for mood conditions and “evil spirits” within the “Thinking too much” genre, the

“attack” and subsequent “feeding” of the “spirits” here are serious and debilitating enough such that the *aj iloneleb*’ and the patient’s family must offer a *toj* (i.e., payment) for the spirit of the illness, a ransom or “replacement” to free the patient from the spirit of the illness.⁶¹ The illness then begins to “feed” on the offering or animal. In this way, the moral positioning of the patient is a central concern with these spirit “attack” conditions, since the spirits of the Mountains and Valleys have the responsibility to preserve the moral and social values of Q’eqchi’ communities.

At midnight, as the truck rolled along the dirt roads outside Punta Gorda, Francisco and Domingo’s father exchanged few words. We drove for about ten minutes before arriving at a small, wooden bridge where Francisco signalled us to stop. Francisco then jumped out and moved over to the bridge and looked out to the small stream below. Francisco bent down over the edge of the bridge and began offering prayers with the now motionless white bag in hand. The area was pitch black and a cacophony of cricket and other insect noises filled our ears. Lightening also flashed several kilometres in the background. Francisco remained in this spot for nearly five minutes. When satisfied with his prayers, Francisco turned the bag over and dumped the duck into the water below.

During the following two days Domingo was closely watched and treated by Francisco at his home. Domingo remained weak and motionless, although generally seemed to be on the path to recovery. The herbal remedy prepared over the last few days was a warm mixture of Devil’s Tongue (*ru’j I rak’ Aj Tza*), a powerful leafy plant in the Adiantaceae family (*Adiantum wilsonii*) primarily used to treat epilepsy and seizures, severe headache, or madness

⁶¹ In most cases it was actually the family of the ill individual that would prepare the animal for the *awas* procedure or purchase an animal especially for those purposes. In this way, the *awas* payment is also a cost to the family who must secure these items in order to assist in the recovery of their family member.

(Bourbonnais-Spear et al., 2005). Thus, Francisco continued to follow a treatment regimen for *rilom tzuul*, or extreme cases of epilepsy.

After the third day of treatment at Francisco's home, Domingo's parents, now visibly worn and tired by the ordeal, expressed the desire to return their son home to Jalacte. We left Punta Gorda later that afternoon, Francisco accompanying Domingo and his parents on the journey. Upon arriving, Domingo's father helped his son out of the car and up to their family home at the top of a large hill. Although apparently strong during the journey, Domingo collapsed into his own hammock while Francisco immediately attended to his patient. Healing prayers, medicinal herbs, burning of candles, *jilok* or spiritual massage, *mayejak* or ceremony, and the *awas* procedure now having a constant rhythm and presence for Domingo and his family.

In the week that followed, at their small and peaceful family home, Domingo remained motionless, save the occasional transfer between hammocks, all the while showing little interest in food. His condition appeared to be stable or even in decline; he was weak and visibly underweight. There were times during Domingo's long periods in bed when only the occasional gust of wind or pecking of a nearby chicken penetrated the silent home. Due to the general lack of change in his patient's condition, Francisco now appeared to alter his therapeutic approach, trying various combinations of medicinal plants (*Puucheche retzul*, *tzul che'*, *ik kehen* and *b'aknel pim*), differing animals for the *awas* procedure (i.e., chicken, fish, turkey, and duck), and other ceremonial procedures or *mayejak*, including intense prayers with candles and deep tissue massage. The once expectant hope of Domingo's parents now waned.

At this time, Francisco suggested to the family that Domingo must have also fallen into a river near a village several kilometres away and, in order to return Domingo to optimal health, Francisco must travel there to do a "calling the spirit back" healing ritual. Thus, the narrative

structure and emplotment of Domingo's case began to take on additional characteristics. This change in narrative necessitated a visit to the location of the suspected fright incident, placing some of Domingo's hair there, offering *copal pom* and prayers, and collecting some water. The water was brought back to Jalacte where Domingo bathed in and consumed it. Since Domingo's condition remained stable, Francisco shifted his therapeutic attention to the *kaanil* he now suspected originally made Domingo susceptible to the *rilom tzuul* condition.

Several days later, in another attempt to re-establish Domingo's health, Francisco and his brother Emilio conducted a two-hour healing *mayejak* for Domingo and his family. This was the first time the two brothers worked on Domingo together; it seemed to be a somewhat desperate attempt to bring out all the healing knowledge in order to help Domingo recover. The healing ceremony started at 8:00 p.m. on the hills behind Domingo's family home. Overlooking the village of Jalacte, and under the bright light of the full moon, Emilio and Francisco began their preparations for the Q'eqchi' *mayejak* that would hopefully assist Domingo's restorative process.

A large bundle of sticks, approximately one foot long and wrapped together with twine was placed into a large, metal cooking pot. These sticks were cut and prepared by Domingo's family earlier that evening. Together, there were about 30-40 short sticks forming a large cylinder about a foot in diameter. Laid out on some palm leaves were additional healing paraphernalia: several candles, four eggs, *copal pom*, and several different kinds of seeds and grains. Domingo's parents emerged from the home with Domingo barely able to walk and visibly weak, clutching onto both parents for support. His parents led him a few short strides away from their thatched dwelling and seated him on a plastic lawn chair. After dropping her son off, Domingo's mother returned inside. Now seated, Domingo faced the moon and his skeleton-like features were exposed by its pale light. His father placed his left hand on Domingo's

shoulder and stood with him as they watched the two brothers prepare the ceremonial and healing paraphernalia.

Emilio poured different seeds and other objects into and around the wooden sticks, while Francisco stood closely and watched. Satisfied with the preparations, Emilio pulled from his bag a red sash that he tied around his waist and a green scarf that he tied around his head. This change of physical appearance signalled the start of the healing ceremony.

Emilio and his brother then poured gasoline into the large metal cooking pot and lit the sticks on fire. The fire was large and added a glowing, red light to the soft paleness of the moon. Emilio took hold of the four eggs that were placed just beside the burning sticks. He held them while offering his words of prayer. His eyes, only visible in bursts of the flickering red light from the fire, gazed hard into the flames. After several minutes Emilio approached Domingo and began moving the eggs over and across his body while he continued offering his prayers. Occasionally he paused, blew on the eggs, and then held them on Domingo's head before returning to his sweeping motions. Domingo remained silent and motionless, gazing into the fire, while his father stood closely to his left side offering his love and support.

Emilio, while never ceasing his words of prayer, continued moving the eggs over and across Domingo's body. At times, he would approach the fire and wave the eggs briefly through the smoke and flames. Following this, Emilio would return to Domingo and once again place the eggs on his forehead. Emilio then held the eggs in front of Domingo's mouth and asked him to blow on them several times. Emilio then approached the fire, and while still in prayer and making several gesturing motions to the fire with the eggs still in hand, he dropped them, one by one, into the flaming cooking pot.

Once all of the eggs were engulfed by the fire, Emilio took 13 different coloured candles from his pile of healing paraphernalia that rested several feet from the fire. While holding the whole lot in his left hand, Emilio removed one candle at a time, offered words of prayer for several minutes, and then placed it in the fire with the eggs and burning sticks. Emilio continued this for nearly five minutes with each candle. Domingo and his father continued to observe the process while staring into the fire. In the midst of his prayers with the candles, Emilio signalled to Francisco who was watching from a few feet away. Francisco understood and right away went into the home. He emerged quickly with a baby duck. While Emilio continued offering his prayers with each single candle, Francisco performed an awas with the duck over Domingo's body. Francisco ran the duck over and across Domingo's entire body while pausing at his head and then his stomach area, his prayers joining Emilio's. Once satisfied with this process, Francisco moved to the healing paraphernalia and, with a small knife, removed the head of the baby duck. Francisco held the duck for a moment while offering words of prayer. The nervous system slowly shut down and the blood drained from the duck's body into a small plastic bowl. After the duck stilled, Francisco placed it into a black plastic bag and glanced at his brother who continued to pray with the candles and proceeded to a small creek behind the house where he left the remains of the animal. Francisco returned and stood between Emilio and the patient. Emilio continued praying with each candle before placing them into the fire.

Once all 13 candles entered the flames, Emilio took a larger, white candle and continued with his prayers. Domingo's father remained beside his son with his arm on Domingo's shoulder. Emilio continued praying for several minutes. Domingo's mother then came outside to join her family and stood to the right of Domingo.

Francisco and Emilio then gave one candle each to Domingo, his father and mother. Francisco and Emilio each held large white candles and moved to stand beside the family. After Emilio lit the five candles, the two healers, Domingo and his parents all began, with the utmost intensity, offering simultaneous prayers. This continued for several minutes. Emilio then signalled the family to place their candles into the fire several feet away. One by one they followed his instructions, Emilio placing Domingo's for him.

Emilio then signalled Domingo's parents to pick up Domingo and move him towards the fire. Domingo's steps were slow as his parents held him tightly on either side. They moved towards the fire and circled it once. Emilio asked Domingo to wave his feet through the fire. With hesitation, he moved his right leg quickly through the fire. He then repeated with his left. Emilio smiled and nodded in approval while signalling that their healing work was complete. Now sweating from being so close to the fire, his family walked Domingo back inside their home. Francisco followed behind and then returned with a large plastic bag full of plant medicine. Emilio took the bag and, while facing each compass direction, began offering prayers for the medication to be effective. Following a short clean-up, Emilio and Francisco headed back to Emilio's Jalacte home. They left the wooden sticks to burn on the hill under the light of the pale moon.

Despite some initial improvements over the last few weeks, the emotional tension in the home grew as, unfortunately, Domingo's condition remained largely unchanged. At this point, the family, Domingo, and Francisco began to seriously doubt their initial hope for a full recovery. Frustration among Francisco, Emilio and Domingo's family was evident. At the outset, Domingo's father was confident that Francisco could help and was eager to get Domingo out of the hospital in order to seek "traditional" assistance. Now, however, after nearly a month of

varying treatments from Francisco, Domingo appeared very ill and his father was open again to seeking help from the hospital and biomedicine.

The day after the evening ceremony, Domingo's father went to the research team requesting assistance with a refill of Domingo's medication from the hospital. The empty bottle read "Nevimune." Nearly one month since meeting Domingo, the research team approached the psychiatric nurse in Punta Gorda regarding the medication; she described to the team her version of Domingo's medical history.

According to the nurse's records, Domingo was confirmed to have a human immunodeficiency virus (HIV) infection two years prior which had since developed into advanced stages of acquired immunodeficiency syndrome (AIDS). Apparently, Domingo had been taking Nevimune and other antiretroviral medications for nearly two years, going to a health centre for regular refills. In addition to developing other influenza-like symptoms, there was also a good chance, the nurse cautioned, that Domingo had contracted tuberculosis (TB), since his immune system was so weak and since TB is present in many of the southern Belize villages. The nurse was anxious to learn about what the Q'eqchi' healers were doing to treat Domingo as well as what his family and *aj iloneleb'* thought of his condition. In a sensitive manner, the research team explained the healer's initial diagnosis of a spiritual sickness called *kaanil* that progressed to *eet aj yahel* and had now become *rilom tzuul*, one of the most serious conditions that Q'eqchi' healers know. The nurse was patient with the story but confident that, since Domingo was in the later stages of AIDS-related illness, the healer's medications would have limited effectiveness. The nurse was especially concerned with how Francisco's unknown herbal remedies might interact with the antiretroviral medications and was surprised to learn that

the father had discharged Domingo from the hospital. It was apparent that neither Domingo's father nor the family knew or fully understood their son's history with AIDS.

The following day in Jalacte, Domingo's parents, who only a few weeks prior were visibly hopeful, now seemed outright angry. Domingo remained motionless on the bed, wheezing and coughing steadily. Apparently, he had been vomiting violently through the night. Francisco and the family talked amongst each other for several minutes while Francisco mixed a fresh batch of herbal medications. Domingo drank the medicine, but immediately vomited the green foamy liquid. After another several minutes of concerned discussion, Francisco opened the Nevimune bottle, pulled out two pills and motioned for Domingo's mother to bring some water. Despite his earlier troubles with vomiting any ingested substance, Domingo was surprisingly able to hold the pills down.

Francisco ultimately recommended that Domingo return to the hospital as there seemed to be no more he could do. Due to Domingo's condition, however, the family felt it was best to keep their son at home in Jalacte. Domingo's father held his son's hand while sitting hunched over on a wooden stool; his mother's eyes teared up as we said goodbye, perhaps suspecting the worse. Later that same evening, the research team received a phone message from Domingo's sister that Domingo had passed on. The funeral was planned to be in Jalacte a few days later and the family invited the team to attend.

Following this depressing and desperate concluding visit, Francisco explained that he suspected something more serious was happening since nothing he did seemed to alleviate Domingo's condition. Francisco did not refer to AIDS during these discussions. Instead, he referred to a "severe sickness" that is "uncontrollable." Francisco's original diagnosis of *rilom*

tzuul still remained the most logical way to conceptualize the seriousness of Domingo's state, although Francisco seemed unsure as to why Domingo was unresponsive to the traditional treatments for the well known condition. In a later interview, the idea of Domingo being diagnosed with AIDS was brought up and the implications were discussed.

In a final interview with Francisco about Domingo's condition, Francisco was asked how he felt regarding Domingo's death. Francisco appeared detached from the situation, perhaps feeling as though there was nothing that could have been done. Francisco explained that he did everything possible and was surprised that Domingo did not improve. Francisco suggested it was as if Domingo was not able or too weak to learn the appropriate social and moral lessons from the "attack" and alter his behaviour accordingly. That is when Francisco knew that something else, besides the *kaanil* and the *rilom tzuul*, was going on. Francisco described:

Even the doctor tried, so Domingo had to die. When he was not suffering he could have looked for help, but he just waited to turn severe then he tried but he didn't have the strength to withstand the pills or the medicinal plants. As he drank the medicinal plants or hospital pills he swallows it but vomits it back. For within two years back he could have looked for help, but now there's nothing we could have done. He still would have died.

Francisco's judgement that the patient and his family failed to take appropriate action in a timely fashion seems, on the surface, to reflect a "self-vindicating epistemology" (Young, 1995). Further reflection, however, suggests a more complex explanation may be needed. The condition from which Domingo suffered was seen differently within biomedicine and the Q'eqchi' healing system, yet practitioners in both medical systems shared a critical opinion of the patient's irresponsibility in failing to act appropriately in his own interests. The biomedical practitioners, invoking existing professional knowledge of HIV and AIDS, set a course of treatment that

emphasized antiretroviral medications and hospital treatment. The Q'eqchi' healers, invoking existing knowledge of sicknesses caused by mountain spirits, "pollution" and fright, set a course of treatment that emphasized herbal medicines, sacrifices, and *mayejak*. Lacking biomedical knowledge regarding HIV and AIDS, the healers conceptualized the patient's sickness within the context of their existing knowledge, a conservative approach to diagnosis that characterizes both traditional healing systems and biomedicine. For the *aj iloneleb'*, while the death of any patient is unexpected, the death of Domingo could be predicted in part because of his own unexpected reluctance to disclose the nature of his illness to his family or to follow faithfully the course of treatment laid out by doctors and healers. The expected success of healing, then, is predicated on the expected compliance of the patient to the treatment regimen; when the patient unexpectedly fails to uphold his part, the unexpected outcome paradoxically, yet logically, occurs.

Normal Science and a "new" Disease

Throughout this work it is posited that mental illness and disorders recognized by the Q'eqchi' *aj iloneleb'* contain narratives with recognizable genres and variations unfolding over time. As Montgomery (2006) observed with clinicians operating in Western biomedical contexts, Q'eqchi' healers work to simplify narratives of disease and disorder "with the hope of reducing them to the bare plot of readily made diagnosis and an obvious therapy. When they succeed, as they often do, the automaticity, the normality that clinicians value is restored" (p. 80). Healers and biomedical clinicians together operate through assumed structures of reality, their paradigm, worldview or, in this case, their cosmovision. When illness is "emplotted" or "domesticated" (Becker, 1997; Mattingly, 1994) within assumed narrative structures and ontological perspectives, the "automaticity of expertise" (Flemming & Mattingly, 2008) or "normality" of a particular therapeutic approach can seamlessly unfold. The cosmovision of the Q'eqchi' healers

and their “narrative genres” operate as what Kuhn (1996) described as the “normal” or ordinary science of Q’eqchi’ psychiatric nosology: it represents the “known” conditions that can impact the mind of a person, the cumulative historical knowledge of ages past combined with years of empirical knowledge, embodied experience, and practice.

In Kuhn’s (1996) “Structure of Scientific Revolutions” normal, natural or ordinary science are terms used to describe a scientific enterprise “firmly based upon one or more past scientific achievements, achievements that some particular scientific community acknowledges for a time as supplying the foundation for its further practice” (p. 10). Natural science, Kuhn further argued, “is the enterprise to force nature into the preformed and relatively inflexible box that the paradigm supplies” (p. 24) and “is directed to the articulation of those phenomena and theories” that are answered within the already given rules and models of a paradigm (p. 24). In this way, “normal science” can be understood as the day-to-day “tacit” functioning that occurs on the basis of already assumed structures of reality that are acknowledged, whether consciously or not, as providing the foundation of practice. Normal science occurs within an accepted paradigm, the work that is performed within an accepted model or pattern of reality.⁶³

The Q’eqchi’ healers’ cosmovision—that is their worldview and ethos—together with their narrative genres of mental illness and disorder, provide a paradigm for the interpretation and construction of meaning within a particular case of illness. Kuhn (1996) suggested that “interpretation presupposes a paradigm” (p. 122) and as such the “texts” revealed and “read” during a medical case, the symptoms displayed, stories told, or diagnostic information provided through the pulse or other bodily ways of knowing, are “emplotted” within a “relatively inflexible box that the paradigm supplies” (p. 24). In this way, the Q’eqchi’ healers are engaged in a

⁶³ Kuhn (1970) also noted that “the existence of a paradigm need not even imply that any full set of rules exists” (p. 44). This is the idea developed by Polanyi (1966), “that much of the scientist’s success depends upon ‘tacit knowledge,’ i.e., knowledge that is acquired through practice and that cannot be articulated explicitly” (p. 44).

process similar to “normal science” insofar as they carry out their work on the basis of certain “achievements” that are acknowledged to supply the foundation for practice. In many ways, these achievements are the different diagnostic methods, like reading the pulse, healing texts, or the therapeutic medication and *awas* procedure. As long as each case falls within or can be employed by one of the previously developed narrative genres of mental illness and disorder, the Q’eqchi’ healers continue their practice in an unreflective, and “automatic” manner.⁶⁴ They simply continue to do what they have been taught and what they have always done. This continuation of practice based on previous assumptions and achievements is Kuhn’s perspective of “normal” science.

This model of “normal science” may continue for the majority of cases encountered by *aj iloneleb*’ but can be challenged when an “anomaly” or “new” illness is introduced that does not have a place within the existing paradigm. As Kuhn (1996) described, novelty or an anomaly “emerges only with difficulty, manifested by resistance, against a background provided by expectation” (p. 64) or “only against the background provided by the paradigm” (p. 65). It has the potential to “call into question explicit and fundamental generalizations of the paradigm” (p. 82). Thus, it is natural and “normal” for Francisco and the other Q’eqchi’ healers to absorb the novel aspects of a medical case within their existing narrative structures. Yet, from time to time, the existing plots and elements of a medical case do not completely fit within their existing narrative structures, challenging and confounding their existing knowledge structures and producing a kind of epistemological liminality. This is what is observed in Domingo’s case.

⁶⁴ As mentioned in Chapter Five, the unreflective and “automatic” processes of Q’eqchi’ healing are not detailed to undermine the sophistication of the clinical empiricism and epistemology of *aj iloneleb*’. Rather, as observed with biomedical physicians operating from Western frameworks (Hunter, 1991; Montgomery, 2006), it is argued throughout that the empirical nature of Q’eqchi’ clinical reasoning involves intuitive and somatic based embodied knowledge. This quality of embodied practice or “somatic attention” (Csordas, 1993, p. 135) is an example of medical expertise, the process by which situated medical knowledge generated from years of empirical observations and case studies become embodied, “withdrawn” and “automatic.”

As Turner (1969) described, a state of liminality occurs when an individual slips “through the network of classification that normally locates states and positions in cultural space” (p. 95), when individuals find themselves outside the “normal” realm of social existence, or when they become “neither here nor there,” or “betwixt and between” (p. 95). As Mattingly (1994) observed, “Any particular event gains its meaning by its place within this narrative configuration, as a contribution to the plot” (p. 813). Thus, the liminal state arises when there are difficulties in placing a particular event or experience within a larger coherent whole, or narrative genre. Liminality of this kind is seen as the absence of a narrative structure, that moment when one diagnostic label and therapeutic approach is exchanged for another, or when the healers begin to reflect upon some explicit or fundamental generalization of their paradigm. As observed in Domingo’s case, any chance of a liminal state is strictly avoided by Francisco and Emilio. This first occurs through a cycling of different plots and narrative structures and by employing adaptive narratives that protect the system of “normal science” (Kuhn, 1996).

The “anomaly,” or aspects of Domingo’s condition that confound the known and experienced response for spirit “attack” conditions are wrapped in multiple narrative genres until a particular ending, its teleology, is reached. This occurs through a cycling of alternative hypotheses and plots. At each moment through this process, however, the Q’eqchi’ *aj iloneleb’* consistently act ‘as if’ they are treating a certain condition, in this case starting with *rilom tzuul*. Francisco follows a treatment approach consistent with this condition, which is the performance of “normal science.” Then, if no expected response to treatment occurs, the healer may construct an additional diagnosis or bring new elements into the narrative drama, as in the introduction of *kaanil*. With this new information Francisco then acts ‘as if’ he is treating a separate condition, and new plots and aspects of the therapeutic encounter are observed. It is the unreflective

normalcy of practice that is called into question in the face of an “anomaly,” forcing a diagnosis to shift empirically throughout the unfolding medical drama.

From one perspective, then, the healer’s actions and attempts at emplotment and narration of Domingo’s case are based on the desire to avoid any permanent sense of liminality. As such it is argued that the operating principle and goal of their healing practice is certitude. Cycling through available narrative structures is motivated by a tendency towards certainty that allows the work of *aj iloneleb’* to occur in an unreflective and automatic manner (Flemming & Mattingly, 2008). Thus, throughout this case a tension is observed between liminality on the one hand—between the mystery of Domingo’s case—and certainty on the other—between the “therapeutic emplotment” of his case within the known structures of illness and disorder.

Eventually, the narrative cycling process comes to a halt. In the ever-worsening patient, there is a realization that something else is occurring. At this stage what could be called a “self-vindicating epistemology” (Young, 1995) emerges, that, in many ways, protects the current Q’eqchi’ medical system and the practice of “normal science” (Kuhn, 1996). These self-vindicating epistemologies are adaptive narratives that are invoked when things go wrong. In this case, that it was perhaps the patient’s “time” to die.

Byron Good (1994) concluded his “Medicine, Rationality and Experience” by suggesting that illness be conceived as an aesthetic object. Just as with a painting or fictional narrative, Good argued that multiple perspectives and points of view are required to fully comprehend the illness experience. As with most theory underpinning the narrative accounts of illness experiences, Good’s reflections primarily originate from the patient’s perspective and move towards a “heteroglossia” of narrative constructions and a plurality of views regarding illness accounts of experience. “Any act of objectification,” Good (1994) contended, “is a moment of

synthesis, but the ‘multiple strata’ resist closure. For each actor involved, alternative representations and the complexity of the object challenge any particular formulation” (p. 170).

For the Q’eqchi’ healers’ illness narratives, although multifarious and overlapping, do not inherently resist closure, nor do their narrative accounts of illness experience challenge a particular attempt at formulation. Their views of an illness condition are not fraught with anxiety and despair, confusion or ambiguity as differing interpretations of an illness episode are in competition. For *aj iloneleb*’ there is certitude, a surety built from their ability to “read” and interpret the different “texts” available amidst medical dramas. This reading is based on their perspective and understandings of cosmovision and their “narrative genres” of similar conditions. From the perspective of healers or medical practitioners, then, is it reasonable to expect such an indeterminate heteroglossia as Good observed for patient’s narratives and experiences? Why is there such a discrepancy in the determinacy of the medical object when shifting our gaze from the patient to the healer? From the view of Francisco and the other members of the Q’eqchi’ Healers Association, their job is to create closure, to cure. Their cultural work is distinguished by a confident resolution of the particular plot and case at hand. The Q’eqchi’ healer’s job, in a sense, is to create focus or a center around which the medical drama can unfold in order to resolve multiple points of view and discount alternatives. Even in the face of a “new” illness condition, Francisco operates on the basis of known therapeutic approaches and diagnostic categories. And even when these categories are revised, the unfolding actions are based upon a surety and confidence within his practice of “normal science.”

Domingo’s case demonstrates that it is only a matter of time before the certitude and unreflective practice of the Q’eqchi’ healers is interrupted in the face of a medical anomaly or “new disease.” Many of the actual symptoms that Domingo experienced, however, are likely

known conditions to the healers, including prolonged fevers, sweats, chills, fatigue, diarrhea, and weight loss (Andrewin & Chien, 2008; Langlois-Klassen, Kipp, & Rubaale, 2008). It is likely, therefore, that what is confounding the healers in this case is not HIV/AIDS as a “new disease,” but rather that these AIDS-related symptoms and illnesses are not responding to the healers efforts because of the underlying immune system deficiencies. Thus the “new disease” here is not so much the constellation of symptoms that negatively impacted Domingo, but rather his underlying immune system deficiency that was largely unresponsive to Francisco’s treatment attempts. It is in this way that HIV/AIDS does not entirely fit within existing narrative structures of illness and disorder, despite the healer’s best attempts at domesticating it as a form of *rilom tzuul* and *kaanil* and thereby treating the symptoms that are known and recognizable. Kuhn (1996) observed that “failure of existing rules is the prelude to a search for new ones” (p. 68) and, as such, it may be reasonable to expect that the more encounters there are with complex syndromes such as HIV/AIDS the more likely the Q’eqchi’ medical system will be forced to adapt in some way. This may be by forming a more sophisticated epistemological complementarity with biomedicine or by adopting or “emploting” AIDS-related conditions within the existing narrative structures of illness and disorder (Mattingly, 1994).⁶⁵

Among Q’eqchi’ communities and the local *aj iloneleb*’ the knowledge of HIV/AIDS and the experiences of the disease are diverse and partial. This may be the beginning stages of the local knowledge system actively working on the construction and meaning of this new syndrome. As observed in Domingo’s case, Francisco approaches the symptoms and illness as a

⁶⁵ As Turner (1969) suggested, however, these liminal states are not only destructive and inherently negative social spaces, but are important insofar as they have the potential to bring about the innate creative forces of human imagination which, when engendered, can transcend the boundaries or current structure of the normal social and cultural order.

condition of known origin and structure. When faced with a sickness, Francisco and the other *aj iloneleb* think in terms of the common things they know, not the exotic things they do not know.

Chapter Conclusions

The first case of HIV/AIDS was reported in Belize City in 1986 (Andrewin & Chien, 2008; Cohen, 2006). According to the United Nations, Belize today has one of the highest incidence of HIV/AIDS infection in Central America, with some 3600 people living with HIV-2 as of 2006 (Government of Belize, 2007). What our research has helped to demonstrate is that Belize is also home to a substantial Indigenous population of Maya people, many of whom have well developed and long-standing healing traditions. Research into the ability of some of their traditional plant medicines to kill the HIV virus has commenced, and while some hopeful results have been reported, it is still too early to know if the rain forest of Belize harbours an effective treatment. This is not to say that *aj iloneleb* in Belize have specific knowledge of the condition, however; despite the high rate of infection, it seems that little is known outside generalized public health messages.

During our ethnographic work with the Q'eqchi' healers in southern Belize, HIV/AIDS was viewed as something that is "new" to them and their knowledge of the syndrome is sparse at best. The origin of the virus is unclear, although links with animals are suspected, but they have learned that sexual contact is a key route of infection. Prior to the case of Domingo, none of the healers in the Q'eqchi' Healers Association knowingly had any firsthand experience with an HIV/AIDS patient. They do, however, treat a large variety of other illnesses, including infectious and contagious diseases. As observed in Domingo's case, there is a connection between what turns out to be a case of AIDS and what the healers assume to be *rilom tzuul* or *kaanil*.

Through the detailed analysis of Domingo's case, what seems to be apparent is that Domingo's experiences of AIDS and *aj iloneleb'* conceptions of *rilom tzuul* or *kaanil* share a certain narrative structure. There are similarities in the plots of these conditions that allow the healers to treat Domingo's experiences as something familiar. The story of Domingo's illness experience involves an initial period of mistake or moral infringement, a kind of spirit "attack" which "polluted" his blood and body. This narrative genre of spirit "attack" serves to "emplot" Domingo's known symptoms and illness experiences (i.e., his sudden falling down, clenching of the teeth, blackish complexion, and unconsciousness), within an already known structure of "mental" disorders (Mattingly, 1994). Underlying and central to this narrative are stories of concern regarding the maintenance of societal, interpersonal, cosmic and cultural values. It is a narrative structure about categories, principles, and relationships that should be respected and fostered, and if this respect and "proper" moral course of action is not followed, a force of "pollution" can occur (Douglas, 1966).

AIDS is often a condition associated with certain kinds of "immoral" or unhealthy behaviours, sexual promiscuity and illicit drug use being the leading factors to its transmission the world over (Langlois-Klassen, Kipp, & Rubaale, 2008). When Francisco suggests in his interpretation of Domingo's case that it is a form of spirit "attack," of some kind of moral reprimand for improper behaviour, a re-examination of the assumed ignorance of the local Q'eqchi' healers regarding this "new" condition is warranted. Why is it that discourses of morality, pollution, and the proper upholding of traditional social and cultural values are brought to bear so readily on Domingo's case?

As observed in Domingo's story, the narrative structure which is employed by the Q'eqchi' healers to make sense of *rilom tzuul* or the spirit "attack" narrative genre is also

employed to make sense of an individual suffering from HIV/AIDS. There is a similar narrative logic that connects these conditions despite the epistemological gulf that seemingly separates them. Like the discursive connection that has developed between traditional or folk illness categories and biomedical understandings of HIV/AIDS in other places around the world (Farmer 1994; Mogensen, 1997; 2000; Thomas, 2008), we might expect an association between AIDS and *rilom tzuul* or spirit “attack” genres in future years or an incorporation of AIDS into the spirit “attack” narrative genre.

CHAPTER VII: Narrative and a Medical Pluralism

Early one September morning our truck arrived at the Punta Gorda hospital in the Toledo district of southern Belize. Manuel Baki, Manuel Choc, Lorenzo Choc and Emilio Kal made their way from the truck to the hospital doors. The Q'eqchi' healers pressed their hands across the wrinkles in their collared shirts and combed their hair as they hesitantly approached the hospital entrance. Nervousness and excitement emanated from the group. Francisco and Thomas greeted the other healers under the veranda at the hospital entrance. They entered together. One of the psychiatric nurses greeted the research team and QHA members and escorted us to a quiet area in the mental health wing of the hospital. The group entered a fairly large, sterile, air conditioned meeting room with a rectangular table in the center and immediately dispersed themselves around the perimeter. Coffee was served as the room was casually examined and chatter began slowly.

After a few moments, the QHA members and researchers were joined by the two Psychiatric Nurse Practitioners (PNPs) practicing in southern Toledo, a psychologist from the Ministry of Health in Belmopan (the Belizean capital), an American physician intern practising at the Punta Gorda hospital, and Claudia Cayetano, Chief Psychiatrist in Belize and director of the Mental Health Department of the Belizean Ministry of Health. The Q'eqchi' healers remained seated on chairs around the room while the others positioned themselves around the table. Light chatter continued among the twelve individuals for a few more moments before one of the PNPs, Mrs. Martinez, formally welcomed everyone to the meeting and thanked each person for taking the time to attend.

“There are several items for us to discuss on the agenda,” Mrs. Martinez began,

After some general introductions and getting to know each other, there is the role of the PNPs in the Toledo district and the model of mental health care practised. Then we can discuss the conceptions of mental health held by the Maya healers and the history of their association including some of the research that has been conducted over the last few years. We can then discuss the relationship with or model of care between our offices and the healers, including the process of referrals. We can conclude with any other questions we may each have with each other. Does this sound ok?

Thomas translated the opening remarks to the healers as they watched from the periphery; some sat humbly with arms folded in their laps while others sipped on their warm coffee. All nodded in agreement.

Each person at the meeting took the time to introduce themselves to the group and talk about their involvement with health and mental health care in Belize. One by one, the Q'eqchi' healers explained who they were, for how many years they have been practicing "traditional" medicine, and what were the most common conditions encountered throughout their practice. Thomas's voice was heard most frequently as he translated the healers' introductions and comments.

After introductions from Ministry of Health staff, Nurse Martinez explained to the healers the role of the PNPs and psychiatrists in maintaining the mental health of individuals in southern Belize. "We serve the needs of persons with mental disorder," she began, "to enhance their quality of life and create networks that guarantee delivery of care within the community. Our work is part of a national program with mental health clinics in all the districts operated by us, the Psychiatric Nurse Practitioners." She went on to explain how PNPs treat all kinds of "mental" disorders or distresses, from depression to psychosis, anxiety or schizophrenia, as well

as alcohol and drug abuse or other psycho-social conditions like domestic violence. The healers listened intently as Thomas related the PNPs' experiences and briefly shared similar conditions that *aj iloneleb* have treated in Q'eqchi' communities.

"We are now at the process in mental health care where we are not institutionalizing our clients any more," Mrs. Martinez continued, "So if we have somebody that comes in and that person needs hospitalization we need to admit them here in our hospital. We admit, we treat, we consult with Cayetano and we give our advice here in the community. It's to promote faster rehabilitation and better quality of life for our patients."

The healers were happy to hear that treatment was shifting away from an institutionalized form of care. They could relate stories of Maya community members being taken to distant places in the north where travel and family visits were difficult. "That is good that they are changing the process of sending patients to the institution," Emilio remarked, "It is good that the difficulties and suffering one's family member goes through is understood and it is good that they go and get treated here in the community rather than just go there alone." There was sympathy and understanding in the healers' comments, as their "traditional" form of mental health care reflects the "community-based model" now implemented by the PNPs and Ministry of Health.

This discussion concerning models of mental health care led to several other questions regarding the treatment and practice of Q'eqchi' medicine. It was clear that this was a unique opportunity for the biomedical practitioners. Cayetano and the PNPs were particularly interested in *aj iloneleb*' case loads, how many patients they typically treat in a week, how long they work with a single patient, how many different conditions they recognize, methods of record keeping,

how much they charge for a healing session, if they openly teach willing apprentices, the ways in which they are contacted by patients, and if they ever refer patients to the hospital or PNPs.

While seated on the edge of the hospital room quietly sipping his coffee, Emilio responded to a few of the questions:

When I treat patients, I would say maybe I go to see them like today in the evening and then like two days after I'd go again and give them medicinal plants and talk to the person that is helping in taking care of the person. Maybe they would stay with me for three days, then after that I would go and visit them in their house in their village. For the three days I would take care of them at my home and I would provide everything for them including medicinal plants. Then when they start feeling better I would give the person taking care of the patient some medicinal plants to give to the patient. The family could pay any amount they can afford. Then they would request that I go and check up on the patient and I must go to them even if they are from another village because that is the work that I do. When the patient is feeling better, I would no longer go back. Sometimes I would visit them again months later and make sure they are doing better.

Throughout his comments, Emilio focused on a notion of “cure,” that when the patient suffering from some form of mental distress is better, they no longer require the assistance of *aj iloneleb*'. This seemed to be a bit difficult for the biomedical staff to comprehend, as they primarily operate on the assumption that many mental illness conditions, especially severe ones, are chronic in nature and endure throughout one's life.

Following this general discussion, the consultation moved on to the mental illness conditions recognized by the Q'eqchi' healers. Our research team presented the biomedical staff with a chart outlining these conditions which emerged from the ethnographic work over a nine

month period (see Chapter Three). The healers suggested that this information might help the PNPs when working with Q'eqchi' patients as they could better understand what illness the patient was going through from their own perspectives. It was an idea well received by Cayetano and the PNPs. Cayetano was also sympathetic to the different conceptions of mental illness held by the members of the QHA. "I think in Belize we are very blessed because we have a lot of culture," Cayetano stated, "I'm Garifuna so I have absolutely no problem with this." She continued while pointing to the chart of different mental illness conditions:

As a Garifuna, we also have our own understanding. In my own culture we have our names and traditions and we respect that if they come to the hospital. We Garifuna believe in healing and all that stuff so that's perfectly okay with me. So I don't have a problem with these things. I think it's only that at which point would they consider that 'this is not my area.' Just like for me I can still tell them if they want to go and do their ceremony that's fine that's not my area and I respect that.

While discussing the different conditions recognized, the *aj iloneleb*' also explained some of their treatment modalities: the use of prayers and *jilok*, medicinal herbs, the *awas* procedure, and diagnostic techniques such as reading the pulse or consulting the Maya calendar. The biomedical practitioners were open and attentive to the healers' stories, yet, in the end, they questioned whether the depression or anxiety treated by *aj iloneleb*' was "really" the same thing that PNPs observe and treat. Did they really treat the same conditions or were these different "areas" of conditions as Cayetano seemed to suggest?

The meeting and consultations concluded with reflections on the working relationship between the biomedical practitioners and the Q'eqchi' healers, as well as the official Ministry of Health policy regarding such a working relationship. It was noted that no official policy or

relationship had yet been established as the Ministry of Health is entirely silent on the role of traditional healers in Belize. The healers were intent to suggest that perhaps such a policy could be created and official roles in their collaborative relationship be demarcated. “Us healers, we do our work on our own,” Manuel Baki reflected to the entire group, “and the hospital does the same work and [we are] not in communication with each other. Perhaps this is the time to work together and know that we actually do almost the same work, but a little bit differently from what we practise.” Thomas translated these heartfelt sentiments to the biomedical practitioners. Consensus among the healers regarding Manuel Baki’s sentiments was indicated by nods of agreement. Cayetano and the other staff were open to these suggestions and again made connections based on her Garifuna cultural heritage. No conclusions were made, but the consultations seemed fruitful. In the end, the twelve people at the meeting shook hands with each other before heading into the heat of the Belizean sun.

Revisiting the Q’eqchi’ Research Program

This work began by introducing Francisco Caal as one member of an important association trying to preserve “traditional” knowledge of Maya healing amidst a welter of societal and historical change. Over the last decade, Manuel Baki, Manuel Choc, Lorenzo Choc, Emilio Kal, Augustino Sho, and several others joined Francisco in this mission. Together with their director, Victor Cal, these individuals created the Q’eqchi’ Healers Association (QHA) representing a quasi-professional way of organizing traditional medical services and an endogenous effort to strengthen, promote and preserve Q’eqchi’ medical knowledge and practice (Arnason et al., 2004; Pesek et al., 2007; Waldram, Cal, & Maquin, 2009). Over the last decade, amidst a backdrop of globalization, modernization, and rapid societal change in Central America and the southern districts of Belize, these *aj iloneleb’* have asserted their legitimacy as medical

practitioners and knowledge experts. They do so not only by appeals to “traditional” ways and knowledge as a means of legitimizing their work, but also through research and collaboration with bioscientists, biomedical practitioners, and medical anthropologists. They emphasize the “traditional” basis of their healing practice, while inviting dialogue with scientists and biomedical practitioners. Q’eqchi’ healers in this research were observed “straddling” between multiple worlds and medical traditions (McMillen, 2004) as they draw on ancient traditions and modern technologies to substantiate themselves as “active agents” in the ongoing cultural reconstruction of their identities as *aj iloneleb’* (Hampshire & Owusu, 2013; Wilson, 1993, p. 136). The current research set out to document important “avenues of hope,” that is the powerful “ingenuity and agency of people and groups at the local level” (Susser, 2009, p. 4). In this contemporary fusion of traditional knowledge and scientific research, the Q’eqchi’ healers are working together to rightly gain the attention of their own Q’eqchi’ communities, the Belize biomedical community, governmental agencies such as the Ministry of Health, and the global scientific and research community.

Since 2003, our research team has been working closely alongside the members of the QHA to accomplish the goals identified by the healers themselves. With guidance from QHA members and Victor Cal, this research involved a nine-month ethnographic study focusing on the conceptions of and treatment practices for different mental illnesses and disorders recognized by the practising *aj iloneleb’* of southern Belize. In addition to, and part of our overall collaboration with the QHA, our research team initiated several dialogues with various members of the Belizean Ministry of Health, exemplified in the opening sections of this chapter. It is hoped that a deeper understanding of the Q’eqchi’ healers and their practices will spur collaborative efforts between their medical work and the biomedical practitioners operating in the same communities

and regions as well as assist in the culturally appropriate treatment of Q'eqchi' patients who experience some form of “mental” illness and disorder. These were the major objectives of this research.

Medical and health related research programs with Maya peoples of Mexico and Central America are extensive (Amiguet et al., 2006; Bourbonnais-Spear et al., 2005; Blanchard & Bean, 2001; Eder & Pu, 2003; Fabrega & Silver, 1973; Harvey, 2006; Kunow, 2003; Molesky-Poz, 2006; Watanabe, 1992). Although vast, the voices, knowledge and stories of local Q'eqchi' healers practising in southern Belize are largely absent from this accruing research. Additionally, previous research has all too often exemplified the “biological gaze” that Nigh (2002) suggested has led to a distorted view of Maya medicine in the scholarly literature, a view which seeks only scientific and biological parallels while marginalizing Indigenous knowledge and worldviews.

What we have seen during our research with the QHA is that the biological and pharmacological aspects of Q'eqchi' healing are only part of a much larger story. For the Q'eqchi' healers, the rational existence and role of *Qaawa'*, the spirits of the Mountains and Valleys, the power of prayer and ceremony, the efficacy of sacrificial offerings, the guiding clarity of pulsing activities and embodied sensations, and the manipulation of pharmacologically active plants coalesce in the treatment of their patients. The current research not only intended to add the voices, knowledge, and stories of local *aj iloneleb'* to the current discussions on Maya healing and medicine, but also, and perhaps more importantly, to highlight a comprehensive and “holistic” view of Q'eqchi' Maya healing and epistemology, specifically regarding their treatment and conception of illnesses that impact the mind of a person. This view bridges the somewhat separate areas of pharmacology, physiology, cosmology, psychology, and spirituality while being grounded within and inspired from Indigenous epistemologies and worldviews.

The current research acknowledged Indigenous paradigms and ways of knowing through a critically engaged moral ethnography. This approach foregrounded a moral axiology to build “authentic” relationships among researchers, QHA members, community members, families and friends (Bull, 2010). It is in this way that participation in the day-to-day lives of community members, conversations and interviews with Q’eqchi’ healers and patients, and observations of clinical encounters occurred during the nine-month ethnographic emersion in Belize (Dewalt, Dewalt, & Wayland, 2000; Jessor, 1996). This “conversational method” of research fostered, at times, an open-ended and flexible structure to the interview process (Kovack, 2010).

At the heart of this entire research process, then, was the emergence of the narrative or story: the story of community members seeking assistance for disabling modes of thinking or disruptive emotions; the story of Q’eqchi’ conceptions of mental illness; the story of researcher and healer consulting together about treatment perspectives; and the story about collaborative approaches between Q’eqchi’ healers and biomedical practitioners. Analysis of these different stories—the specific episodes embedded in the individual interviews with healers as well as the overall “story” of the case studies observed—allowed us to examine and analyze the narrative construction and structure of Q’eqchi’ mental illness and disorders. These stories are central to an Indigenous research paradigm and a Q’eqchi’ program of research, which, in the end, informed the major arguments and contributions of this work regarding the narrative structure of Maya medical knowledge.

Narrative Genres of Q’eqchi’ Mental Disorders

Storytelling or narrative is a common mode of describing perspectives of reality, the relationships sustaining reality and day-to-day experience. As Kovack (2010) suggested while reflecting on the nature of Indigenous epistemologies, “Stories hold within them knowledge

while simultaneously signifying relationships” (p. 94) and that “there is an interrelationship between story and knowing” (p. 95). What we have argued throughout this research is that Q’eqchi’ conceptions of mental illness and disorder engender a narrative framework or structure. Within these narrative structures, or what we have come to call the different “narrative genres” of Q’eqchi’ mental illness, is important knowledge of Q’eqchi’ medical reality and the personal, interpersonal, and cosmological relationships that helps to sustain and abound within those visions of reality. In other words, the stories about mental illness that were detailed in this research project are stories about relationships; each outlines a disruption and resolution of relationships in some way.

Although research from both Western and Indigenous epistemologies has used narrative in its approaches and methods, most narrative research of illness and healing in cultural psychiatry and medical anthropology has been about patient experiences, representing a “narrative turn” in various disciplines (Becker, 1997; Garro & Mattingly, 2000; Garro, 1994; 2010; Kirmayer, 1996, 2000; Waldram, 2010). To examine how stories or narratives are constructed by the Q’eqchi’ healers to guide, as part of their healing epistemology, the interpretation and treatment of mental illness and disorder is, however, somewhat unique. Throughout our research, narrative forms of representing reality have provided insight into the synthetic processes through which Q’eqchi’ “mental” illnesses are constituted, shaped and treated. In addition, a great deal was revealed about the practical concerns regarding the cultural shaping of “mental” illness and the nature of “cross-cultural psychiatry” more generally (Gold & Kirmayer, 2007; Good, 1994; Kleinman, 1977; 1988; Lewis-Fernandez & Kleinman, 1994; Littlewood, 2002).

The detailed interviews with the members of the Q'eqchi' Healers Association reveal that narrative is not only a form in which experience is represented and recounted, in which events are presented as having a meaningful and coherent order (Bruner, 1986; Mattingly & Garro, 2000; Waldram, 2010), but also a medium through which the epistemological structure of Q'eqchi' medical reality is revealed and understood. It was argued throughout this work that Q'eqchi' "narrative genres" signify a "common stock of stories" that enable *aj iloneleb* to recognize, create meaning from, and enact cultural scenarios with which they are familiar (Good, 1994; Mattingly, 2000, p. 197). It is the way in which clinical time and patient experiences are "domesticated" or "emplotted" by *aj iloneleb*' narrative genres that concerned us throughout this research (Becker, 1997; Mattingly, 1994). And it is in this way that the different mental illnesses recognized by the Q'eqchi' healers represent competing narrative structures, genres, or plot forms allowing the healers to, as Ricoeur (1981) suggested, "extract a configuration from a succession" (p. 278).

In Chapter Two the main arguments were advanced by looking at Q'eqchi' cosmovision as a "formative process" or "interpretive activity" that underlies and informs the narrative structure of Q'eqchi' medical knowledge (Cassirer, 1955). As the worldview and ethos of contemporary Q'eqchi' healers (Geertz, 1973), cosmovision shapes the perspectives of reality to maintain, norms of acceptable models for behaviour, values to uphold, stories to tell, worthwhile pursuits, and aesthetic sensibilities. Explored in detail were the spirits of the Mountains and Valleys, the gatekeepers and moral guards of Q'eqchi' communities, and the proper or respectful relationships that individuals and communities are to have with the other-than-human realm. At the heart of these proper relations is a "culture of reciprocity" or a "relational complementariness" that Molesky-Poz (2006, p. 42-44) suggested is central to Maya visions of

the world. A moral economy of permission was explored within a “moral causal ontology” (Shweder, 2003) wherein the *toj* or “payment” was made to the other-than-human realm in order to maintain and sustain proper relations between spirits and humans. This notion was reiterated throughout this work as a risk or protective factor related to the onset and development of several mental illness conditions. If the proper relationships are maintained, it is thought, then the spirits of the Mountains and Valleys will protect the individuals; whereas, if one fails to uphold the proper modes of conduct, then they risk being “punished” by the same spirits and morally corrected for their wrongdoing. The concept of *maatan* was also reviewed as important in the construction of Q’eqchi’ illness narratives, both of patients and healers. Here the day of someone’s birth or moral actions of the parents are the important risk or protective factors determining the likelihood of illness. Finally, this chapter reviewed the concepts of Q’eqchi’ metaphysiology and personhood, including the notions of mind, body, spirit, and heart that underlie and inform many stories of health and illness that abound in Q’eqchi’ communities. The narrative structures of Q’eqchi’ mental disorders are the product of societal, cultural and historical processes that contribute to their contemporary articulation and construction, a great deal of which is informed by the *aj iloneleb*’ perspectives of cosmovision.

After setting the stage by reviewing current perspectives of Q’eqchi’ cosmovision, Chapter Three presented the main arguments of the dissertation and reviewed the four “narrative genres” held within *aj iloneleb*’ epistemological structures of mental illness and disorder. It was argued that each of the 17 mental illness conditions recognized by the healers could be positioned within one of the four broader narrative genres (see Figure 1). Rather than working as discrete categories, however, these 17 conditions and the four narrative genres were presented as different dimensions of illness experience and the narratives that delineate or “emplot” that

experience (Mattingly, 1994). As Mogensen (1997) suggested, “people define disease not through categorical thinking but through narrative logic, elements that contribute to the plot, the narrative structure” (p. 435). Following suit, it was suggested that the four “narrative genres” of mental illness and disorder are provisional templates for a story with a discernible plot structure, casts of characters, themes, genres, recognizable teleology or “directedness,” theodicy, and soteriological elements akin to the theatrical categories of the comedy or the romance. Similarly, while working with physicians in Western medical settings, Montgomery (2006) observed that “Narrative accounts of disease mechanisms or pathological processes are the principle means of organizing symptomatic clues and their interpretive syndromes” (p. 64). In like manner, our research team argues that the “narrative genres” recognized by the Q’eqchi’ healers have important qualities and characteristics, plots and actors, significant events and props, that signal for them, and those within Q’eqchi’ communities, what specific story will unfold and what they are likely to encounter.

Chapter Four detailed how the specifics of each “narrative genre” are worked out, filled in, or “emplotted” through the patient and healers’ idiosyncratic interactions (Mattingly, 1994). Here we developed Mattingly’s (1994) concept of “therapeutic emplotment” by exploring how “narrative genres” function as provisional templates or structures for the unfolding of the mental illness episode, and how they are negotiated in actual clinical time. The Q’eqchi’ clinical encounter is far from preordained by rigid cultural scripts; rather, it has “emergent” properties similar to those which Mattingly (2000) observed. The healers’ negotiation of a clinical case was performed analogously as “readers” of their patient’s “texts,” a process referred to as a kind of “narrative reasoning” (Flemming & Mattingly, 2008). This process involves a circular, hermeneutical interpretive act that moves between the cultural logics underlying their

cosmovision, the abstract generalities of different “narrative genres,” and the “texts” of a specific case available to be “read” by the healers. As expert readers, Q’eqchi’ healers draw on their familiarity of the plots of similar cases as well as the dialogical knowledge that “emerges” during several diagnostic practices (i.e., reading of *copal pom*, pulsing of the blood). The *aj iloneleb*’ not only “see” a specific patient, but also “read” into each case based on prior knowledge (i.e., narrative genres), and they read teleologically, suggesting and organizing possible outcomes and salutary actions. Finally, this ability to “read” a case in Q’eqchi’ medicine, we argued, is a kind of knowing that is not strictly speaking hypothetico-deductive. It is a kind of “intuitive knowledge” and a process well-tuned by several Indigenous peoples and familiar within Indigenous epistemologies (Castellano, 2000; Davis, 2009; Smith, 1999).

In Chapter Five the relation between embodiment and narrative was outlined. Here the main arguments were advanced through an analysis of embodied or somatic types of knowledge and how they relate to or function together with an understanding of the “narrative genres” of mental illness and disorder. This chapter focused specifically on how bodily knowledge or “empathetic intercorporeality” (Harvey, 2006, p. 909) informs the “reading” process of Q’eqchi’ clinical judgement while also looking to the body as an additional “text” that healers employ to interpret the unfolding events of illness experiences as they play out within a specific case. For the Q’eqchi’ healers, their body is both a diagnostic instrument and a text, that is, an instrument that creates or produces the text. Further, bodily sensations were seen to guide therapeutic “improvisation” and the “emergent” properties of Q’eqchi’ clinical encounters (Mattingly, 2000). The propositions of the previous chapter and literature in this area were also advanced by suggesting that the “narrative rationality” described by Hunter (1991) and Montgomery (2006), and the “narrative reasoning” outlined by Flemming and Mattingly (2008) both involve bodily

processes or forms of “intuitive” based somatic knowledge that guide the dialogical “reading” of medical “texts.” The Q’eqchi’ healers long years of attending to patients is largely a somatic practice, a kind of “tacit-knowledge,” “know-how,” habitus or enduring bodily disposition—an embodied, pre-conceptual and non-propositional type of embodied knowledge and perception allowing them to move and treat their patients in often “automatic” ways (Csordas, 1993; Hinojosa, 2002; Merleau-Ponty, 1962; Polanyi, 1966).

Chapter Six described a particular case that does not fit easily into the existing narrative structures for Q’eqchi’ mental illness and disorder. Rather than a smooth and uncomplicated diagnosis and treatment, this chapter explored the problems or disruptions that can arise when a condition fails to narratively “fit” within existing narrative genres. The Q’eqchi’ healers’ perspectives of cosmovision and their “narrative genres” operate as what Kuhn (1996) described as the “normal” or ordinary science of Q’eqchi’ psychiatric nosology, the “known” conditions that can impact the mind of a person. The “texts” revealed and “read” during a medical case, the symptoms displayed, stories told, or diagnostic information provided are “emplotted” within a “relatively inflexible box that the paradigm supplies” (Kuhn, 1996, p. 24; Mattingly, 1994). In this chapter a condition originally emploted within the spirit “attack” narrative genre turned out to be a case of HIV/AIDS. There was a similar narrative logic observed to connect these conditions at first, despite the difficulty in narratively “fitting” this case completely within existing narrative structures in the end. Eventually it becomes clear that the immunodeficiencies associated with this condition signalled a “new” illness falling outside the known structures of Q’eqchi’ medical reality. As a result, there was a shifting or cycling between different diagnoses to avoid uncertainty or liminality as a result of the new condition. Liminality of this kind was detailed as the absence of a narrative structure, when one diagnostic label and therapeutic

approach was exchanged for another, or when the *aj ilonel* began to question some fundamental generalization of the known paradigm. When the condition seems to progress and get worse, and a narrative cycling seems ineffective, a “self-vindicating epistemology” was employed (Young, 1995). In the end it is asserted that it is simply the patient’s “time” to die, an adaptive narrative strategy invoked when things go wrong within a particular case and a way of limiting the experienced sense of liminality and augmenting the restoration of clinical certainty. It may be that this “new” condition will shift the existing paradigm or “known” narrative genres in Q’eqchi’ medicine. It is also possible that the “new” condition will become “domesticated” into the working structures of Q’eqchi’ medical knowledge (Becker, 1997). Either way, this chapter furthers the overall arguments of the research by highlighting important elements of *aj iloneleb’* narrative reasoning, clinical judgement, emplotment and the structure of narrative genres within Q’eqchi’ medical practice.

Intertextuality and the Aesthetics of Therapeutic Texture

As argued throughout this research, the process of reading diagnostic “texts” and constructively narrating healing “texts” can be understood as a kind of “therapeutic emplotment” (Mattingly, 1994). This process involves not only situating a case within a general taxonomy of illness conditions, but also inserting specific healing “texts” within the unfolding drama that helps guide the illness narrative towards some desired future outcome. Both what the healers “read” and what they performatively insert into the unfolding therapeutic drama are informed by or based on their understanding of “narrative genres” of similar conditions. In this way, the Q’eqchi’ healers are empirical in their approach: they “know” what might work in a particular case because it was done before in a similar situation. They improvise, narrate and read on the basis of contexts and genres already familiar. The overall emplotment of a particular case does

not occur through any single text, however. The patient's story, information from the pulsing of the blood, reading of the *copal pom*, or bodily sensations are not enough on their own to signal for the *aj iloneleb*' what appropriate plot they are in and what therapeutic interventions or healing "texts" are likely to assist a specific case. Rather, what we see in the work of Q'eqchi' medicine is a plurality of texts weaving together to create a particular medical drama.

In all of the cases reviewed in this research, therapeutic emplotment was determined through a plurality of "texts." Additionally, emplotment of the medical case oftentimes occurred in the absence of or in even in contradiction to the story told by the patient. Thus, the narrative casuistry of Q'eqchi' medical practice can be observed even where the patient's story is absent. The patients have no direct control over what their blood will communicate to the healer, what is spiritually imprinted onto a lump of *copal pom*, or what is suggested to a healer through bodily sensations. If one "text" is unavailable to the healer, a host of others can be "read" in any particular case.

What is observed in Q'eqchi' medicine is not simply a plurality of texts coming together in a single therapeutic encounter. What is also observed is that the reading of one text forms the basis of or a starting point for the interpretation of another. These reflections speak to the inherent "intertextuality" of Q'eqchi' therapeutic encounters; that is, the factors that make the interpretations of one text dependent upon one or more previously encountered texts. In literary theory, successful communication between the text and a reader is dependent upon prior knowledge, without which intelligible communication will break down, understanding will become obscured, and meaning non-existent (Iser, 1978). Intertextuality here speaks to the ways in which Q'eqchi' medical "texts" stand in relation to one another to produce meaning or to shape the overall therapeutic plot. The healers' pulsing activities logically follow from or are

interpreted on the basis of previously encountered texts; the stories told, symptoms displayed or previous experiences with a similar case or narrative genre. The process of shifting between the diagnostic and therapeutic elements of a case also follow a logical and coherent sequence.

Intertextuality of the therapeutic encounter thus refers not only to the reading of the current case on the basis of previous “narrative genres,” but also to the ability of inserting new healing texts into the unfolding drama that logically follow from the current narrative structure of events. In Domingo’s case detailed in Chapter Six, this logical coherence broke down in the presence of a “new” condition and a state of liminality arose, disrupting the unreflective certainty of *aj iloneleb*’ practice.

On the basis of previous knowledge, then, the construction of healing texts often emerges during clinical time in a spontaneous and improvisational manner. The Q’eqchi’ healers have some sense of how to proceed based on the narrative genres of similar cases, but the actual unfolding of clinical events and insertion of healing “texts” occurs through the reading and narrating different “texts.” The healers’ logic, therefore, follows what is referred to as a kind of *intertextual narrativity*, a hermeneutic strategy that moves from case to narrative genre and back again, all the while seeking to construct an overall coherence within the unfolding narrative. And as explored in Chapter Five, this process largely occurs on the basis of an “automaticity of expertise” (Flemming & Mattingly, 2008), and through an unreflective and pre-objective embodied mode of engagement with the world (Csordas, 1993).

The synthesizing therapeutic and diagnostic activities of the Q’eqchi’ healer bring together divergent sources of information. It is in this way that the art of Q’eqchi’ healing is a “holistic” enterprise. “One way of understanding clinical encounters,” Hurwitz (2000) suggested, “is to see them as complex processes of story construction and exchange, where fragments of

experience in different stages of narrativity are elaborated and pieced together” (p. 2087). Indeed, through their narrative reasoning, *aj iloneleb*’ process an endless flow of data, the reading of their patients’ blood, position of the *copal pom*, sensations within their own bodies, their patients’ symptoms and signs, and their narrated course of events. As we isolate, deconstruct or even celebrate these specific aspects or “pieces” of *aj iloneleb*’ medical practice, we run the risk of losing sight of the overall picture. The Q’eqchi’ healers’ work excels not so much in the particular but in the whole, the manner in which these different “texts” come together within any particular therapeutic encounter.

As alluded to throughout various chapters, this “holistic” process is reminiscent of the dialogical work of a reader, observing one action or event after another while imaginatively entering into the unfolding narrative drama. As Good (1994) and Iser (1978) contended, the interpretive, hermeneutic act of reading is an act of synthesis, as readers are adept at integrating the diverse viewpoints (i.e., texts) within a single narrative to form a comprehensive picture of the story. As Iser (1978) noted, this process of reading is not a single, final act but an ongoing process, a blending of history and anticipation, past and future, a “moving” or “wondering viewpoint.” As Iser (1978) explained,

The reader’s wandering viewpoint is, at one and the same time, caught up in and transcended by the object it is to apprehend. Apperception can only take place in phases, each of which contains aspects of the object to be constituted, but none of which can claim to be representative of it. Thus the aesthetic object cannot be identified with any of its manifestations during the time-flow of the reading. The incompleteness of each manifestation necessitates synthesis, which in turn brings about the transfer of the text to

the reader's consciousness. The synthesizing process, however, is not sporadic – it continues throughout every phase of the journey of the wandering viewpoint (p. 170). As they dialogically read and insert different texts, the Q'eqchi' healers are involved in a synthetic process; they engender a "wandering viewpoint" allowing them to imaginatively enter the case at hand by seamlessly moving between particulars and generalities. It is from this imaginative process that the healer-readers come to "know" the story, the central characters, the genre or plot at hand. It is this "knowing" that, as Good (1994) observed, "requires a synthesis that transcends any particularity" (p. 170) and it is this knowing that is "intertextual" in nature. The work of Q'eqchi' *aj iloneleb'* brings together multiple texts and "wandering viewpoints" to create an overall coherence in the medical drama. This overall process can be understood as an *aesthetics of therapeutic texture*, the overlapping and weaving together of multiple views in a clinical case.

In literary theory, "texture" is the basis for unity and semantic interdependence within a text. Lacking this would create a random collection of isolated sentences with no relation to each other. Effective healing encounters, it is argued, are thus connected to a healer's ability to create texture. In the reading of different diagnostic "texts" and the construction and insertion of healing "texts," texture is created; a tapestry of different views being drawn together in a single aesthetic object or therapeutic encounter. This weaving of different texts or creation of therapeutic texture facilitates, for the patient, the process of meaning construction, the goal of "therapeutic emplotment" (Mattingly, 1994). The Q'eqchi' healers' ability to alter a patient's disruptive experiences (i.e., the "success" of the therapeutic encounter) is largely dependent on the aesthetics of therapeutic texture, the ability of the healer to create meaning by linking the different elements together. The texture of the clinical case is the dialogical relation between text

as diagnostic element and text as therapeutic element. Therapeutic success, therefore, depends on the quality of aesthetic texture, on the degree of “holism” or “sequential implicativeness” (Iser, 1978). What may be central to questions of healing efficacy, it is argued, involve the degree or quality of this aesthetic process: How many texts are available to the healer? How does the healer bring these together in the therapeutic encounter? How is texture constructed? Is the plot intertextual? What contexts inform the reading and narrating of a particular case? Future investigations into similar processes of healing may be informed by a therapeutics of texture.

Emerging Insights from a Narrative Lens

By looking at the conceptualization and treatment of Q’eqchi’ medical practice through a narrative lens, and by working to explicate the narrative structure of Q’eqchi’ mental illness and disorders, several key insights emerge. First, it is clear that the narrative genres of mental illness are informed by contemporary forms of Q’eqchi’ cosmovision and cultural practices. The objects of Q’eqchi’ medical reality and narratives of disorder are culturally situated and in dialogue with other ideological systems and modes of practice such as biomedicine or various forms of Christianity. This research demonstrated that contemporary nosological perspectives of the Q’eqchi’ *aj iloneleb*’ comprise a relatively stable core of illnesses known to impact the mind of an individual. This is not to say, however, that Q’eqchi’ medical knowledge is static or hermetically sealed. Rather, like Lock and Nitcher (2002) observed with medical traditions such as Ayurveda and Chinese medicine, Q’eqchi’ medicine is open, dynamic, and is capable of creative synthesis as contact with other medical traditions increases. Seeing disease states as narratively constructed allows us to appreciate that cultural influences are implicated in the articulation and construction of illness categories while acknowledging their flexible nature to adapt and respond to new situations and contexts. Previous research attests to this notion

specifically regarding the adaptation of local medical systems to the relatively “new” illness condition HIV/AIDS (Farmer 1994; Mogensen, 1997; 2000; Thomas, 2008). Future work with the Q’eqchi’ *aj iloneleb’* of southern Belize could continue to explore the narrative construction and articulation of “new” illness conditions such as HIV/AIDS.

A second insight emerging from this work is that the Q’eqchi’ healers rely on the ultimate casuistry of narrative amidst clinical encounters, a judgement or reasoning process that is shared with biomedical practitioners. Several important studies conducted over the last few decades have delineated the narrative reasoning that underlies clinical work in Western biomedical settings (Charon, 2006; Flemming & Mattingly, 2008; Hunter, 1991; Hurwitz, 2000; Hurwitz & Charon, 2013; Kirmayer, 2006; Mattingly, 1994; 2000; 2010; Montgomery, 2006; Waldram, 2012; Wood, 2004). Indeed, Hunter (1991) concluded, “as a human enterprise, medicine speaks primarily through the narratives its practitioners construct as hypothesis about a patient’s malady, the stories that convey the medical meaning they have discerned in the text that is the patient” (p. 26). The different processes of this kind of “narrative reasoning” were highlighted and reflected within the healing practices of Q’eqchi’ *aj iloneleb’* (Hunter, 1991; Montgomery, 2006). This points to a perhaps unsuspected convergence between clinical judgement in the practice of biomedicine and “traditional” Q’eqchi’ healing. There are many parallels here, however. Both biomedical and Q’eqchi’ medical practice are engaged in a clinical reasoning process that is empirical in nature and employs the casuistry of narrative. The use of the terms “empirical,” or “rational” to apply to biomedicine alone, therefore, is unwarranted, as many aspects of Q’eqchi’ “traditional” healing are equally rational and empirical. As other researchers have suggested for Ayurvedic, Unani, and Chinese medicine (Lock & Nichter, 2002;

Ross, 2012), perhaps it is time to acknowledge the rational and empirical principles present in contemporary Maya medicine.

This conclusion forces us to re-examine an assumption held in the second half of the 20th century: that with modernization and Westernization, a scientific medicine and epistemology would come to dominate medical perspectives forcing people to abandon “traditional” medicines and resort primarily to “modern” biomedicine (Lock & Nichter, 2002). The work of the QHA illustrates a grass-roots form of revivalism and supports a powerful counter-narrative to the triumphalism oftentimes associated with modern biomedicine (Waldram, Cal & Maquin, 2009; Wilson, 1993). Several aspects of Q’eqchi’ medicine have retained a firm foothold in the face of modern biomedicine and globalization. In addition, the politics of Indigenous sovereignty, identity, and nationalism—spurring on movements of professionalism and research such as the formation of the QHA—have not only helped establish a position for “traditional” Q’eqchi’ medicine in the 21st century, but also its potential expansion.

Parallels between traditional Q’eqchi’ medicine and Western biomedicine are further observed regarding the role of the patient. As we have seen throughout this research, the patient holds a minimal role in Q’eqchi’ healing. The Q’eqchi’ healers consult with the different “texts” available to them in the clinical episode. These different diagnostic texts are “read” almost entirely without the patient’s knowledge or volition. In a similar manner, the technological equipment characteristic of contemporary biomedicine allows a Western clinician to read into the patient’s body and experiences regardless of what the patient has to say. An X-ray or blood test, some would argue, will often reveal the “truth” of a medical story more accurately than the medical narrative as presented by the patient. In both cases, the healers’ “tools” explicate the medical narrative in the near absence of or with minimal input from the patient. In other words,

patients hold a similar ontological and epistemological position in both Q'eqchi' healing and biomedicine. When switching our narrative lens from patient to healer, therefore, a different understanding of narrative emerges: a perspective in which cosmology, biology and spirituality can construct a narrative in the absence of the patient's effort, their individual "self," or co-construction (Harvey, 2008; Kirmayer, 2007).

Through the Q'eqchi' healing interaction the "narrative knowledge" about the patient is constructed in quite a different manner than described elsewhere (Charon, 2006; Hurwitz & Charon, 2013). Narrative knowledge, Charon (2006) suggested, involves "recognizing, absorbing, interpreting and being moved by the stories of illness" (p. 4) and "provides one person with a rich, resonant grasp of another person's situation as it unfolds in time" (p. 9). This kind of knowledge, Hurwitz and Charon (2013) described, is constructed primarily through direct dialogue between patient and healer. In Q'eqchi' medicinal ontology, as is often the case in biomedical oncology, it is the disease of the person that is treated as a foreign object, an entity or "spirit" that can, in some cases, "attack" an individual like the assault of a serpent. The Q'eqchi' healers' focus and attention, therefore, is centered on this foreign entity, on removing or taking out the illness that is inflicting the patient. As we have seen, this also includes a therapeutic focus on the lived immediacy of pre-objective bodily practice (Csordas, 1997). In this way, the patient's narratives only have utility insofar as they assist *aj iloneleb'* to locate and deal with the specific malady. Thus, when speaking of the "holistic" aspects of Q'eqchi' medicine, we are not referring to ideals of integrative medicine where mind, body and spirit of the person are engaged equally in the therapeutic encounter. This is not necessarily the approach of the QHA. Rather, "holism" in Q'eqchi' medicine refers to the degree to which the different "texts" within a particular case are weaved together to construct the narrative of the illness

episode—an aesthetics of therapeutic texture. The examples detailed through our study suggest that the current perspective of Q’eqchi’ healers is that “good medicine” can still occur while focused entirely on the extraction of a disease entity present within the patient. The individual “self” or “egocentric” person that is emphasized in Western biomedical practices, it would seem, is not the most pertinent aspect of the clinical encounter in Q’eqchi’ cultural contexts (Good, 1994; Kirmayer, 2007). This point is reflected in many aspects of biomedicine (Lock & Nguyen, 2010).

This research also reveals some insights regarding the manner of conceptualizing mental illness conditions through a narrative lens. Our vision of Q’eqchi’ mental disorders as narrative structures allows us to see the inherent flexibility and adaptability that often accompany the illness narrative. The specifics of each case can vary, yet the overall plot has a certain amount of coherence lending it, in most cases, intelligible and familiar to a practising healer. A narrative approach to the conceptualization of mental illness is by its very nature a dimensional enterprise, resisting rigid classification systems between conditions while allowing continuums and variations. This is an important perspective regarding the diagnosis and classification of mental illness and disorder, a perspective maintained and fostered through the publication of various DSM “case books” and the parallel Psychodynamic Diagnostic Manual (PDM) (Spitzer et al., 2002; PDM Task Force, 2006). The “clinical illustrations” within the PDM as well as the case presentations in the DSM’s Case Book together highlight the notion that “medical diagnosis itself is both an interpretation...and a trace marker for larger narratives with their own multiple histories, vocabularies, writers, and audiences” (Wood, 2004, p. 196). Thus, our argument pertaining to the narrative structures of Q’eqchi’ mental disorders can also, in many regards, apply to the Western diagnostic systems espoused in the DSM; that is, they are not themselves

culturally-free entities, but rather explanatory models or “narrative frameworks” specific to Western contexts and cultural systems (Kirmayer, 2006; Wood, 2004). This conclusion elicits questions about what “narrative genres” of mental illness and disorder may guide and structure Western psychiatric practice. Can “Mood Disorders” “Schizophrenias” or “Anxiety Disorders” be thought of as different narrative structures of mental illness? What might this conception lend to the treatment of mental illness and disorder in other cultural contexts and settings?

This brings final reflections on the assumed supremacy and scientific valour often accompanying Western classification systems. As Hunter (1991) observed, “A recognition of medicine’s fundamental uncertainty and the well developed tradition of narrative that is central to its epistemology might help to moderate our society’s unrealistic expectations of medicine’s work” (p. 48). Indeed, as Good (1994) concluded,

It is my conviction that making explicit the narrative and moral dimensions of routine clinical practice, investigating illness in the context of local moral worlds, and rethinking medicine’s common sense epistemological claims are means by which medical anthropologists may attempt to resist the encroachment of instrumental rationality into this domain of the lifeworld (p. 181).

The “instrumental rationality” here is a kind of thinking that prevents dialogue among alternative cultural views. Realizing the inherent narrative processes that underlie clinical work—in both Q’eqchi’ traditional medicine and biomedical practice—may be enough to promote a sought-after dialogue between the two systems in places of contested medical plurality like Belize.

Narrative and a Medical Pluralism

The meeting that took place in the Punta Gorda hospital described in the opening sections of this chapter is emblematic of a sought after complementarity and process of dialogue between

traditional forms of Q'eqchi' healing and biomedical practice. Currently in Belize there are no official policies or working relationships between the governmental biomedical agencies and the various forms of traditional medicine practised throughout the country. Some Belizean reports do note that "Indigenous healers" are prevalent in the southern regions of Belize (Killion & Cayetano, 2009), and reports from the WHO explicitly state that "some of the resources spent on the mental hospital would be best diverted to prevention training of primary health care personnel and alternative/traditional practitioners who are the gate keepers of many rural communities" (p. 25). Aside from the current research conducted with the Q'eqchi' Healers Association, the extent to which "Indigenous healers" in Belize effectively maintain and promote mental health in various rural communities has not been the subject of intensive inquiry. The current addition to the National Mental Health Policy in Belize 2010-2015 remains entirely silent on the issue of local or traditional healers (GOB, 2010).

Since the complexity of disease, mental illness and human suffering are best understood from multiple perspectives or orientations (Good, 1994), it is suggested throughout this work that the Belize Ministry of Health should take into consideration the views and knowledge of the local *aj iloneleb'*. The goal is to prevent, on the one hand, an undesirable uniformity of illness conceptualization that so often follows the cultural hegemony of biomedicine, and augment, on the other, the treatment and care for individuals with mental illness, disorder or distress in Belize. One objective of this research was to demonstrate to the medical and psychiatric communities generally, and the Belizean Ministry of Health particularly, that Q'eqchi' healers are important factors in the primary mental health care in southern Belize. Working under the auspices of the QHA, it is suggested that a collaborative and dialogical approach to mental health care would be

most prudent and that biomedicine should be complementary to, and not competitive with, the traditional health care services.

From two parallel perspectives the members of the QHA observe a troubling health and mental health situation in Belize. On the one hand, the traditional Q'eqchi' medicine system is slowly eroding. With one exception, none of the healers we worked with are training apprentices. The youth are forced to apply for more economically viable jobs and apprenticing as a healer is losing appeal. Traditional medical knowledge is being lost as the elders die. As Hawkins and Adams (2007) similarly observed with Maya medicine in Guatemala, "A faith in modernity, a belief that opportunity lies outside the municipality, corrodes adherence to local "traditional" and therefore "old" medical practices" (p. 219). The contemporary work of the QHA and the research documented throughout this dissertation are "hopeful" attempts at reviving Q'eqchi' medical practice and preserving the rich medical knowledge and epistemology of this "great" medical tradition (Waldram, Cal, & Maquin, 2009; Susser, 2009; Wilson, 1993).⁶⁶ As good as their attempts are, however, it is likely that Q'eqchi' *aj iloneleb* will eventually require assistance from the official government system, such as the Ministry of Health, in order to secure their sought after goals.

On the other hand, the governmental health system is often absent in many of the most remote Maya communities. Few medical doctors, psychiatrists or PNP's desire to practice in Maya communities and villages and, when they are present for weeklong trips to the "remote" areas, feel uncomfortable not understanding the local language, social predicaments, cultural traditions, or perspectives of medicine (Bonander et al., 2000; Killion & Cayetano, 2009; Staiano, 1981). Given this situation, then, it may be prudent for the Belizean Ministry of Health to consider steps to ensure that the traditional health system remain a viable option in remote

⁶⁶ See also footnote three in Chapter One.

areas of southern Belize. Moreover, given Belize's economic conditions and structural or transportation limitations, it is unlikely that the biomedical system can provide adequate mental health care in Maya villages without somehow forming a collaboration with the traditional healers already working in the remotest of areas. For reasons of economic feasibility alone, the biomedical system may do well to more explicitly support traditional medical practice; otherwise, these issues will only increase as Maya populations expand (WHO-AIMS, 2008). The challenge will be for biomedical practitioners to recognize and acknowledge that many components of Q'eqchi' medical practice are an effective means by which mental health care can be administered to Maya populations, especially to the most impoverished, distant, and rural (Bonander et al., 2000; Hawkins & Adams, 2007).

Dialogues and collaboration between Q'eqchi' medicine and the biomedical system may also advance more surely if concerned governments or international agencies sponsored research specifically to investigate the efficacy of particular Q'eqchi' health practices (i.e., common household remedies, massage, prayer, or herbal medications, as well as certain psycho-social treatments). Such validation would likely add to cultural acceptability by enabling both medical practitioners and Q'eqchi' Mayas to understand the value of Maya health and mental health practice through the idiom of biomedicine appreciated by the wider Ladino and Carib society of Belize (Staiano, 1981). Through such scientific backing, an appropriate respect for the valid components of Indigenous epistemology and medical practice could be taught throughout Central American medical schools. Indeed, incorporation of traditional medical knowledge into university education, several authors suggest, is the key to long-term, mutual esteem and integration among different medical systems (Hawkins & Adams, 2007).

The obstacles to creating dialogue between Q'eqchi' and biomedical systems are largely due to epistemological differences. As such, the particularities of what should be synthesized and how it should be organized require an understanding of local culture and knowledge. The ethnographic descriptions and analysis in this research signify meaningful steps in this direction. This is not the only issue under consideration, however. A thorough examination of the local medical milieu of biomedicine as embodied and adapted within the Belizean context is also required to aid dialogue between the traditional and biomedical health systems. This would help to uncover assumptions, understand barriers to working with local *aj iloneleb*, and provide the grounds for a common language that could be used when speaking across the epistemological divides separating these two medical systems.

Although recent literature has emphasized the importance of embracing medical pluralism in international health initiatives (Bodeker & Kronenberg, 2002; WHO, 2001), several studies also acknowledge potential risks of moving toward a plurality of medical systems. In working to establish dialogue and collaboration between biomedicine and Q'eqchi' healing in Belize, it will be important to acknowledge these potential pitfalls.

In some instances around the world, the development of medical pluralism has led to complex processes of social exclusion, where marginalized populations continue to lack access to health services (Das, 2003). In grassroots contexts of medical pluralism, for example, the deployment of pluralism may actually act to conceal forms of suffering and structural problems around health care delivery (Farmer, 1996). Moreover, as Broom, Doron, and Tovey, (2009) observed regarding the integration of Ayurveda and biomedicine in southern India, "Medical pluralism, while reflecting important richness in cultural knowledge and practice, emerged as inextricably linked to forms of social inequality and suffering" (p. 704) and that "contemporary

economic conditions were seen as resulting in new forms of healthcare polarization (and conspicuous philanthropy) that mediate and limit access to care depending on one's prognosis, age and other socio-demographic variables" (p. 704). Along similar lines, several other researchers are increasingly critical of "plural" processes wherein biomedicine incorporates or "appropriates" Indigenous medical knowledge, while ignoring or denigrating the underlying epistemological assumptions (Lock, 1990; Janes, 1995). Indeed, Langwick (2008) described this process as "institutionally articulated medical pluralism" in which biomedicine stands accused of "colonizing" and "co-opting" traditional medicine as a "resource" for biomedical endeavours and underlying economic agendas (p. 428).

Although as I mentioned in Chapter One there may be unforeseen risks when advocating for medical policies that are more receptive to plurality and integration, and that as Susser (2009) suggested, "there is the risk here that one can make major mistakes and advocate for policies that backfire on the downtrodden," this is a risk, Susser also argued, "we all take as citizens of the world" (p. 14-15). Indeed, the implications of Psychiatric Nurse Practitioners (PNPs) forming relationships with Q'eqchi' healers cannot be determined fully. Nor can the implications of formally documenting the Q'eqchi' conceptualizations of various mental health conditions be grasped. Yet, failing to move in these directions and face new questions as they emerge is a scenario that the QHA members and this research team are not willing to consider. All of these issues, both the positive and negative aspects of medical pluralism, are important to consider for our Belizean context and raises questions: Can biomedical services be offered in a dialogical manner with local healing approaches or are they by nature associated with a hegemonic, colonialist enterprise? How do we fashion an epistemologically coherent position that makes

sense of the claims of human biology and biomedical science while still acknowledging the validity of local knowledges and Indigenous epistemologies?

In the end, our research team suggests that insights into some of the problems, challenges and issues of medical pluralism may be found by again looking through a narrative lens. In her work on “Narrative Medicine,” Charon (2006) described case after case of doctors increasing their ability to meaningfully connect with their patients, to listen to the stories they tell and sympathize with their experiences and perspectives of illness. This ability to connect or “affiliate,” as she described, is part of “narrative knowledge,” of being able to “understand particular events befalling another individual not as an instance of something that is universally true but as a singular and meaningful situation” (p. 9). In other contexts, Charon (2006) observed how training in “Narrative Medicine” assists different members of the health care team come together and create a common story regarding the work they perform. Charon (2006) continued,

Narrative medicine recognizes that some of the skills currently missing from medicine are, in fact, narrative skills, that we know what narrative skills are, and that we know how to teach them. Literature departments, creative writing courses, anthropology and ethnography departments, and psychotherapy training programs, among many others, have developed well-tested methods of teaching students how to read, write, and interpret texts; how to systematically adopt others’ points of view; how to recognize and honour the particular along with the universal; how to identify the meaning of individuals’ words, silences, and behaviours; how, as a reader or a listener, to enter authentic relation with a writer or a teller or a text; and how to bring one’s own thoughts and sensations to achieving the status of language (p. 10).

It is these “narrative skills,” Charon (2006) later suggested, that produce “affiliations” as the outcome of narrative work, “healing affiliations with patients and collegial affiliations with our fellow nurses, doctors, and social workers” (p. 219). “The divides in health care,” she further posited, “are like countless other divides—in education, in politics, in religion, in marriages—bridgeable by virtue of the narrative powers of telling, listening, gathering around any kind of campfire to hear one another out” (p. 219). “Shared narrative acts build community,” Charon (2006) firmly concluded, “It can also make room for egalitarian groupings of health care professionals and sick people, together on the ground opened up by illness” (p. 219).

Through her detailed work in some of the top medical settings in Western cultural contexts, Charon (2006) has observed many instances where the virtues and powers of narrative create affiliations between doctor and patient, nurses and doctors, managerial staff and researchers, or families and their dying relatives. In all of these instances, by virtue of coming together to share one’s perspective of the situation (i.e., to negotiate differences, entertain alternative views, and work together to construct a vision of the future), affiliations and unity were created where separation and difference once resided.

It seems reasonable to conclude that a similar process of “narrative work” be employed in the contexts of Belize. Charon’s (2006) work did not go beyond the bounds of a Western cultural framework, nor did she theorize how well her findings might apply between cross-cultural settings where differences in epistemology, ontology, language and interpretation loom large. Yet, it seems logical to suggest that just as “affiliations” were forged between disparate sectors of a health care setting in the United States, similar affiliations might be forged between health care providers from different backgrounds in Belize (i.e., between biomedicine and those practising “traditional” forms of healing and health care). Indeed, when the members of the

Q'eqchi' Healers Association entertain dialogues with the members of the Mental Health Department in the Belizean Ministry of Health, we suspect it is precisely the kind of “affiliation” Charon (2006) described that is slowly emerging.

Steps towards a meaningful system of medical pluralism, one that is sympathetic to local perspectives and epistemologies of Q'eqchi' medicine and honours the important role of biomedicine, would likely begin with consultations and dialogues with all those interested in the outcomes of such a discussion. Like those morally grounded interviews or “conversations” building “authentic” friendships as part of our overall research goals (Bull, 2010; Kovack, 2010), these dialogues may be an important first step in seeing the perspectives of the “other,” to entertain alternative views, and work together to construct a vision of the future (Charon, 2006). Again, as Charon (2006) observed, “shared narrative acts build community” (p. 219). Medical pluralism in Belize may be dependent on biomedical practitioners and “traditional” healers co-constructing—through the powers of telling, listening and gathering—a common narrative about the health and mental health situation in the country. Through this process they will begin to build community and forge new relationships. “Perhaps,” as Manuel Baki suggested during his meeting with Cayetano and the other Ministry of Health staff, “this is the time to work together and know that we actually do almost the same work.” This research was a step towards a more collaborative direction. It is our hope that this is only the first of many.

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Appendix A: Lexicon of Q'eqchi' calendar as described by Emilio Kal

Glyph symbol	Q'eqchi name	English name	Lexicon of day names and their significance
	Kej	Deer	The four pillars that sustains the sky and the earth, it is the force that carries the destiny of humanity. Kej represents the four cardinal points (Tojil, Ab'ilix, Ajka B'i O, Makotaj). It is a day of solid foundations, of unity. When harmony can be attained in groups, a day of authority and honesty. A day for consultation.
	Q'anil	Seeds	The day of seeds or semen. Good day for animal fertility, planting and reaping an abundance of harvest, plant and animal health, for plant germination, for giving birth. The day that guards all kinds of seeds and yeast. Good day to ask for seeds, to have an abundant harvest, to begin a project.
	Toj	Payment (Offering)	Signifies offering, payment, and a charge. It is a day to be in peace with God and with the brother. hidden things are brought to light. A good day to ask that the spirit is strengthened, for the forgiveness of sins committed, or to keep away storms, suffering or accidents. It is the nawal of land, and also signifies rain. Give offering every 20 days.
	Tz'I	Dog	A day of material and spiritual justice. A good day to judge what is good and what is bad, that justive prevails, that we are free from those that criticize, to keep away poverty, that we do not fall into negative habits or addition. Good day to investigate the truth.
	B'atz'	Time (Monkey)	Signifies the time developed, of human evolution giving us life. A day to calm mischief and undo sickness, good day for becoming Maya priest, asking for clothes for the body, unite persons in marriage, to put things in order, to ask for spiritual strength, for painters and sculptors, and development of the arts in general. A good day to begin or initiate an activity. The day marking human origins, a link with the past.
	E	Path (The road)	Good to ask for business, to keep us free from temptations on the road, to ask for help in a new project, to complete a contract. Signifies the nerves in the human body. Day of marketing and the development of history. Signifies the good road, the stright road or destiny.
	Aj	Staff (Cornstalk)	Signifies the staff of the power of the seven virtues or the divine clairvoyance power, sacred words, the love for humanity, telepatic signals in the body, inspired dreams, sacred knowledge of sex and the development of fire and power serpent. Also signifies the home.
	Ix	Jaguar	Signifies the Maya Altar or Tab'al or Potojil. Day of feminine energy. Good day to ask to be free from habits or addiction, to ask for valor and power, ask that animals don't eat the harvest and that are homes are safe.
	Tz'ikin	Eagle (The bird)	Signifies the bird and the intermediation between man and God. It is the nawal of money, love and art. It is a special day for Mayan ceremony or nuklem. Also a good day to free us from sickness, as for protection in business, ask the Heart of Sky and Heart of Earth for protection, take away sadness or anger, or take away poverty
	Ajmaq	Vulture	It is a day to ask for forgiveness for sins and for the sinners. It is a day dedicated for the dead. Good day to ask for forgiveness, good day for curing sickness, asking Ixchel and Itzama for assistance, ask for the dead to help in defending a community. Good day to stop negative spirits that are causing illness. A symbol of the moral forces, a day of remembering dead ancestors.

Glyph symbol	Q'eqchi name	English name	Lexicon of day names and their significance
	N'oj	Knowledge (Wisdom)	Signifies knowledge and wisdom. A good day for students, to ask that you will do well in school, to change the negative character of a person, that medicinal plants have power. Relates to the movement of forces or changes.
	Tijax	Suffering (Obsidian blade)	A day of sacrifice and suffering. A reminder of the struggle ancestors faced. A good day to ask to be free from temptations, accidents in the workplace, road accidents, ask for good sings in the blood, in spiritual ceremony and in dreams.
	Kawoq	Difficulties	Signifies fights and difficulties. It is an appropriate day for the <i>Aj Q'ijab'</i> to burn pom in his staff/baston, pot or his/her beans. A day for judges, lawyers, and those who intercede for health or an end to problems. A day to stop the suffering of a mental illness.
	Ajpu	Sun (The hero)	Signifies the cervatana. A special day to do spiritual ceremony or the xukdem. A good day to ask for crops to be fruitful, that sick are revived, protection for farmers. Ajpu is a hunter of animals. Ajpu was one of the hero twins in the Popul Vuh who passed through death and was revived by the sun. A good day to triumph over difficulties.
	Imox	Water (The lake)	Signifies stupidity and madness. It is all that corresponds to the left that is negative. A good day for a woman to return to her husband, or a person to come home who has abandoned their home, to ask that the madness in the homes ceases or calms down.
	Iq'	Air (The wind)	Signifies the air, the wind and spirit. It is the heart of sky that gives us strength and life. Nim Kaqul ha', Rax Kaqul ha', and Xip Kaqul ha'. It is the sacred breath, the of winds that fill us with sacred life. IQ' is Ixmukane, the last quarter of the moon or the old moon. Her womb Ixb'alanke, new moon.
	Aq'ab'al	Harmony (The dawn)	Signifies the aurora and the hand, it is the light and darkness. The dawn, symbol of the first rays of the days. The sun banishes darkness, a day of peace and hamony. A day to ask the hidden things are brought to light, marriage is enlightened.
	K'at	Fire (The womb)	Signifies network and fire, captivity, and oppression. It is a good to entangle, snare, or wind something, but also a day to untangle. Good day to form a group or organization. Good day for giving birth to a normal child, midwives are strengthened.
	K'an	Serpent	Signifies the Plumed Serpent, creator and former of universe, it is justice, the truth and peace. It is an angry day. Symbolizes the coiling of creation. The sign of the creator, the Founder, the duality of good and bad. Vision of the Maya people.
	Keme	Death	Signifies the nawal of death. Prognosticates what is good and what is bad. Nawal of the women priest and of the sun. Powerful day when in balnce for asking sickness to be taken away.

Appendix B: List of Q'eqchi' terms and phrases

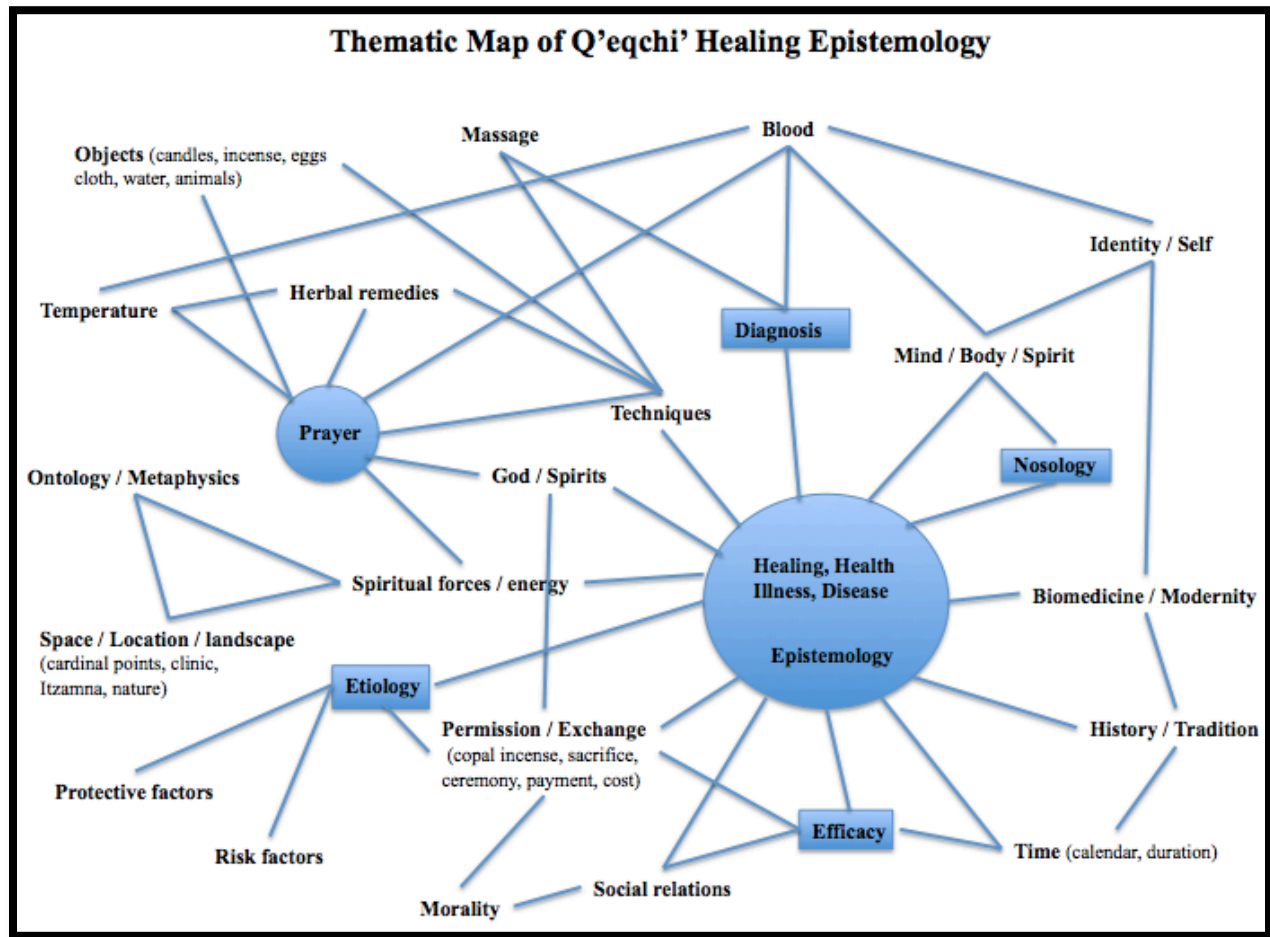
Q'eqchi' term	English translation
<i>Aam</i>	Heart
<i>Agouti</i>	Animal used in <i>awas</i> . Related to gibbon family, a “royal rat”
<i>Aj ilonel</i>	A word that could be used for a traditional healer translates as “seer” or “one who sees” as in the one who sees patients. It comes from the root word “ <i>ilok</i> ” which literally translates as a verb meaning to see
<i>Aj ookil</i>	The state of being awake
<i>Aj q'ijab</i>	A <i>kaqchikel</i> Maya term for “spiritual guides.” Also used in Belize
<i>Aj Remer</i>	A person doing the treating of a condition.
<i>Awas (healing practice)</i>	Sacrifice, replacement, ransom, offering, exchange (a difficult word to translate, used to refer to the process of killing animals during healing in order to “take out the days of the sickness,” “to take out the scent of the sickness,” or “to take out the pain of the sickness.”)
<i>Awas (illness condition)</i>	An illness that children can get when the parents do something bad during pregnancy or look at a strange animal. The parent’s fault then translates to the child who is born with some kinds of deficits. Term is used to explain why some children are born with deficits or “mental retardation.”
<i>B'oqok mu</i>	Prayer used in “fright” conditions translates literally as “calling back the spirit.”
<i>Ch'ool</i>	Soul
<i>Ch'e'ok kik'</i>	Prayer about talking with the blood. Used to diagnose <i>kaanil</i> on Apr 28th 2011 by Francisco
<i>Ch'i' ch'i'</i>	Body not happy, person is miserable, experiencing irritation
<i>Cha'al</i>	Body
<i>Chaab'il</i>	Beauty, good, cute, or pretty
<i>Chaabil yu'an</i>	Good life or “well-being”
<i>Chahimal</i>	Synonymous with <i>maatan</i> , “star of the person,” or gifts of the person,
<i>Chan kru na'ilok</i>	Symptoms: phrase meaning “how does it look like”
<i>Chi'</i>	As used in Q'eqchi' (refers to dark skin, as in people with dark skin. Also can refer to craboo a type of tree).
<i>Chij</i>	Prayer (noun)
<i>Chijok</i>	The act of Prayer (verb)
<i>Chiqwual (as in xjolom)</i>	Heat or hot (illness of the hot head)
<i>Eet (as in eet aj yahel)</i>	Is a state of a person being irritated, stubborn, not wanting to listen to others, or very moody, not friendly or angry. (Difficult to translate)

<i>il</i>	Signifies a condition or state that is happening to the person
<i>Inka sa ch'ool</i>	Phrase meaning soul is not happy can be a synonym for <i>rahil ch'ool</i> which is the word used for depression
<i>Jilok</i>	A kind of spiritual massage used in healing. Is often translated as “knighting” the person.
<i>Jolom</i>	Head, the physical body part
<i>K'atol mayej</i>	Refers to spiritual guides, literal translation, “one who burns the ceremony.”
<i>K'atol xam</i>	Also used to refer to spiritual guides
<i>K'axum xul</i>	Snake bite. Literally translate to the bite of the snake. Snake = <i>xul</i> bite = <i>k'axum</i>
<i>K'ay (as in waxk'ay)</i>	Literally means “sale,” to sell something
<i>K'ochob'ank</i>	Prayer used in “thinking too much” healing many conditions. Translates as “set up” or “arrange the mind,” “alter mentality,” or “stabilize the mind.”
<i>K'a'uxl</i>	Mind or thinking
<i>K'alib'aal</i>	Community
<i>Kaanil</i>	The root is “ <i>kaan</i> ” means being frightened but specifically, in <i>kaanil</i> , means being frightened by a river.
<i>Kaw</i>	Healthy or strong
<i>Kawilal</i>	Health, strength, both physical and more broadly in terms of the bodies ability to resist sickness
<i>Kik'el</i>	Referring to blood
<i>Maatan</i>	“Gift” from God, destiny or luck of the person
<i>Mayej</i>	Can be used to refer to “sacrifice”
<i>Mayejak</i>	Ceremony (the root <i>mayej</i> is also used as sacrifice)
<i>Mu</i>	Literally means “shadow.” The root word used to describe the spirit of a person. It is what is trapped in <i>kaanil</i> .
<i>Muhelej</i>	Spirit (literal translation) it is a noun
<i>Muqmu</i>	Hidden or secret. As in a secret about how to treat a particular condition
<i>Musiq`</i>	A verb description of what spirit is like (i.e., breath, or air we literally breathe). These two are used interchangeably to describe spirit. And there is no difference between animal spirit or human spirit or other spirits. Only one spirit.
<i>Na'leb' OR k'a'uxl</i>	Knowledge. <i>K'a'uxl</i> is also the word used for mind
<i>Nawal</i>	Synonymous with <i>maatan</i> : gift from God, destiny
<i>Naxutaanak</i>	The condition of frightened blood. Shy or ashamed as in the blood being scared.
<i>Oksinb'il kaan</i>	Another term for illness caused by being frightened from behind. It could be someone pretending to be a ghost scaring another. This kind of fright can cause sickness.

<i>Oxloq'</i>	Sacred
<i>Permis (spanish)</i>	Permission
<i>Pim or q'ehen</i>	Referring to the medicinal plants
<i>Po'ol (as in po'ol k'a'uxl)</i>	Something spoiled or damaged
<i>Pohol</i>	Synonymous with <i>maatan</i>
<i>Q'eq</i>	Black (as used in Q'eqchi, can also refer to “strong”)
<i>Q'eq pojink</i>	Strong blood
<i>Qaawa'</i>	God: <i>Qaawa'</i> (same for mountain spirits, all encompassing creator God, or Christian God) also same as Dios.
<i>Qab'aanuhom</i>	Refers to custom or traditions, the ways of life, the customs, what we do as a people
<i>Qanawom</i>	Also refers to customs and traditions, the ways of life, the customs, but also has an emphasis on what we know as a people as opposed to what we do as a people
<i>Ra xch'ool</i>	Sad. Literally hurt heart or soul
<i>Rahilal</i>	Suffering: “ <i>rahilal</i> ” – the root “ <i>ra</i> ” means sad – this refers to a state of sadness, sickness or pain, suffering and sadness, as when someone is sick
<i>Remerik</i>	Prayer used in treatment meaning is “to heal.” Also, act of treating someone. Also the name of the prayer most commonly used to treat someone.
<i>Rilom Tzuul</i>	A kind of epilepsy, “a mountain that sees a person,” illness of the mountain spirit, the mountain spirit came and looked at the person and they got ill, a person turns black
<i>Ru</i>	Face
<i>Sa</i>	Nice
<i>Sa xch'ool</i>	Content: (as in contentment)
<i>Sa xch'ool</i>	Happy (“nice heart”)
<i>Sachk</i>	State or condition of being “lost,” as in not finding your way in the woods. In need of a guide.
<i>Sahil ch'oolejil</i>	Happiness (literally, “contentment in one’s soul”) <i>q'eq pojink</i> – strong blood (“black solid”)
<i>Sahilal</i>	Contentment or happiness
<i>Suerte (spanish)</i>	Luck
<i>Svete</i>	Spanish term meaning luck. Used almost synonymously with <i>maatan</i> or <i>nawal</i> . The luck of the person is related to his days. Or his inner gifts.
<i>Tib'l (as in Tib'l jolom)</i>	Pain (used for headache)
<i>Tkamsi rib</i>	Suicide: (a phrase meaning to kill him or her self)
<i>Toj</i>	Word used for payment, as in payment to evil spirits during awas

<i>Tuqub'ank</i>	Word used to “stabilize the mind.” It is a general term to stabilize or balance anything, like a cup on a table.
<i>Tuul</i>	Witchcraft, meaning the act of making another person sick.
<i>Tyajel ma'us</i>	“Illness of the evil spirit.” Used to refer to <i>eet aj yajel & rilom tzul</i> .
<i>Tzolok</i>	To learn, the act of learning.
<i>Ulul or k'a'uxl</i>	Brain
<i>Wank se' kutank</i>	Literal translation: being in days. (i.e. days not with one's wife). Used in translations as the term referring to abstinence.
<i>Wax (as in wax ru)</i>	Behavior that is crazy, an action, can be used in other discourse to refer to someone who is in a hurry or who, for example, comes into a house in a storm looking for something moving though everything quickly looking worried.
<i>Xb'amb'al</i>	Treatment
<i>Xch'ool</i>	Emotions. There no real word for “emotions” generally, but there are terms for specific moods
<i>Xib'emb'il</i>	Illness caused by being frightened from behind by another person. A version of <i>kaanil</i>
<i>Xiw xiw</i>	A state of a person that is afraid. More general than <i>kaanil</i> . Someone afraid of everything, loud noises or imaginary things like being worried that the police might arrest you for no apparent reason.
<i>Xiwajenak</i>	Fright or frightened. Overarching term that is used to describe all fright conditions (i.e., <i>kaanil</i> , <i>xib'emb'il</i> , <i>oksinb'il kaan</i>)
<i>Xjolom</i>	<i>Jolom</i> = head x = signifies male or female
<i>Xk'ulub'ankil</i>	Word used for “acceptance” (noun). The act of accepting is <i>k'ulub'ank</i> . Used in conversation talking about needing to accept someone who died in order to not become sick (<i>rahil ch'ool</i>)
<i>Xkawil xch'ool</i>	Courage: used in conversation with Francisco Caal April 28th about <i>kaanil</i> patient when asking about protection from fear. This term can mean to be successful, to be strong, or to overcome challenges.
<i>Yahel</i>	Sickness or illness
<i>Yaj</i>	Sick
<i>Yajel</i>	Sickness

Appendix C: Thematic map of Q'eqchi' healing epistemology



Note: This thematic or conceptual map is a rough sketch of the major themes related to Q'eqchi' healing epistemology that arose within the interview transcripts. The terms highlighted are those which the healers mention in great detail or which are referred to frequently and in a variety of different contexts (i.e., prayer, nosology, efficacy, etiology, diagnosis and healing epistemology). These are the broader themes under which a number of the smaller themes fall within (Smith & Osborn, 2003). The lines attempt to highlight some of the interactions between and relations among these different themes and concepts. It must be stressed that this process of mapping Q'eqchi' healing epistemology is an inherently flawed practice due to the sophistication,

complexity, and embodied nature of Q'eqchi' medical epistemology. This is only an interpretation of the healers' interpretations of their medical practice articulated in a manner not common for the *aj iloneleb*' (see Chapter One). Thus, this thematic map is used only as a loose heuristic to help the reader visualize the different themes and concepts that arose during the analytic stages of this research.

Appendix D: Semi-structured interview guide

Note: When the actual interviews occur during fieldwork moved through one of the following interview sections at a time. Thus, took several months to go through all of the following questions. Furthermore, these questions were simply a guide for the ongoing “conversations” with *aj iloneleb* and will most likely not be asked in a formal question and answer setting. All of the stems for research questions arose from preliminary discussions with QHA members and the research project coordinator Victor Cal or from analysis of James Waldram’s previous interview data with the same group of healers. Previous research with the Q’eqchi healers in southern Belize also guided the interview guides (Bourbonnais-Spear et al., 2005).

a) Healer interviews:

Conceptualization of cosmovision (The key here is develop an understanding of Q’eqchi’ spirituality and religion (i.e, cosmovision), including the role of God and spirits in reality and daily life, how humans communicate with them, and their role in healing and illness).

1. What is your current relationship to religion?
2. How would you describe religion to someone?
3. What was religion like when you were a child?
4. What do you think religion will be like in the future?
5. Is religion a part of your healing practice? Why? How?
6. Do you have a relationship with any religious institutions?
7. Is a belief in God necessary for healing?
8. Do you ever go to religious ceremonies?
9. Do you ever read religious scripture?
10. Do you pray on your own?
11. What does prayer mean to you?
12. Why is prayer used in healing practices?
13. Who do you pray to?
14. How important are the specific words used in a prayer? (after recording certain prayers I can ask the healers about some specific things mentioned).
15. What words are used? Why those specific words?
16. Do things in life happen for a reason? Why or why not?
17. What is the purpose of your life?
18. Have you ever felt some kind of “presence” during healing? If so, what is this like?
19. Do you feel there is a reason why you became a healer?
20. Do you think all people have some relations to spirits? To mountain spirits?
21. What is necessary for people to have relations with spirits and with God?
22. What would stop someone from having a relation to Spirits or God?

23. Why might a relationship with Spirits / God be important for Q'eqchi' people? Why might these relationships be important for other people?
24. What would you say makes someone's life of value?
25. What are things you think are sacred?
26. How should we behave around sacred things?
27. Can God or spirits influence daily events?
28. What kinds of power does God or spirits have? Where does this power come from?
29. Where does your healing power come from?
30. What is power?
31. What does the word energy mean to you?
32. What is the difference between God and spirits?
33. Does God control the spirits?
34. What powers does God have that spirits do not? And vice versa?
35. Are there different illness associated with God and spirits?
36. Are spirits people that have now died?
37. How do spirits or God communicate with people?
38. Do you communicate with spirits? How often? How? Where?
39. Do Spirits act in your daily life?
40. Do Spirits act in everyone's daily life?
41. How do you know there are spirits?
42. Have you ever seen a spirit?
43. Why do certain spirits live in the Mountains? Forests? Water?
44. How do you know God exists?
45. Can spirits or God influence daily common objects? How, why?
46. How do you know what is right or wrong?
47. What kinds of sin are there?
48. How do you know if someone has sinned?

Conceptualization of Mind, Body, Spirit, Self & Other: (The key here is to develop a conceptualization of the mind, body and spirit from Q'eqchi' perspectives).

- 1) What is your understanding of the mind?
- 2) Where is the mind?
- 3) What is the heart?
- 4) Where is the heart?
- 5) What is the relation between mind and heart?
- 6) Can people become sick in the mind? Heart?
- 7) How does this happen?
- 8) What factors lead to a healthy mind?
- 9) What factors lead to a healthy heart?
- 10) How can you heal the mind?
- 11) What are some illnesses of the mind that you have treated?
- 12) What are some illnesses of the spirit that you have treated?
- 13) What are some illnesses of the body that you have treated?
- 14) How have you treated these cases?
- 15) Why did the person get sick in these cases?
- 16) What is the human spirit?

- 17) What is the relation between mind and body?
- 18) What is the relation between mind and spirit?
- 19) Can an illness of the mind impact the body? Heart?
- 20) Can an illness of the body impact the mind? Heart?
- 21) Are there certain locations that can cause mental illness?
- 22) Are there certain times of the day, week, month, year where people can get sick more than other times?
- 23) What is the relationship between family or community and mental health?
- 24) Is there a purpose for someone becoming ill?
- 25) Is there ever anything positive that comes to a person after becoming ill?
- 26) Can mental illness be a good thing?
- 27) Can mental illness ever help someone's family?
- 28) Is the human spirit related to the mountain spirits? What is the difference/similarity?
- 29) Are peoples bodies connected in some way?
- 30) What is the relation between people? Between spirits?
- 31) What is the difference between people and animals? What qualities do we have that they don't?
- 32) What would you say are the main characteristics of a person?
- 33) Are people connected in some way not by physical touch?

Nosology: (The key here is to develop comprehensive nosology of mental illness and disorder from Q'eqchi' perspectives so to be able to critically compare this with DSM diagnostic criteria).

- 1) What are the different illnesses you recognize?
- 2) What are the different mental illnesses you recognize?
- 3) How many mental illnesses conditions are there?
- 4) Have you ever seen epilepsy/seizures (*eet aj yajel*)? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?
- 5) Have you ever seen headaches? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?
- 6) Have you ever seen susto (*kaanil*)? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?
- 7) Have you ever seen depression (*rahil chol*)? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?
- 8) Have you ever seen numbness? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?
- 9) Have you ever seen), insomnia (*aj okil*)? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?
- 10) Have you ever seen stress (*ch'I chi il*)? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?

- 11) Have you ever seen memory loss (*sachal ch'ool*)? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?
- 12) Have you ever seen fear (*xiw xiw*)? Are there different kinds? What can you tell me about this condition? How many cases have you treated? Is it a sickness of the mind, body, spirit? Some combination?
- 13) Are there other conditions you have seen/treated?
- 14) How is our mind involved with sickness of the body? How about our spirit?
- 15) How is our body and mind involved with sickness of the spirit?

Etiology & Diagnosis: (The purpose of this section was to understand the different causes for illness conditions and how the healers determine this through diagnosis).

- 1) What techniques do you use to determine if someone is sick?
- 2) How do you know what sickness someone has?
- 3) How do you know when someone is ill or sick?
- 4) How important is it that the right sickness is known before treatment?
- 5) Do spiritual forces like prayer or ceremony assist in diagnosis?
- 6) Does God help with diagnosis?
- 7) Can spirits help with diagnosis?
- 8) What does the blood pulse tell you about a person?
- 9) How do you know what someone's pulse means?
- 10) What is the role of prayer in diagnosis?
- 11) Can you know an illness without using prayer?
- 12) Do you have to ask the patient about their experiences to diagnose the illness?
- 13) How long does it take you to figure out what illness someone has?
- 14) How often are you correct about a particular diagnosis?
- 15) How often do you change your diagnosis after trying a particular treatment?
- 16) How important is the day and time for diagnosis?
- 17) Are there certain times of the day that are better for diagnosis? Why or why not?
- 18) Are there things you need to do in order to know what illness someone has?
- 19) Can anyone diagnose an illness condition?
- 20) Can diagnosis occur without the sick person being present? Through spirits, family or friends? If so how, why?
- 21) Are there certain places better for diagnosis?
- 22) Do you talk with the patient's family before making a diagnosis?
- 23) To what extent are peoples dreams used in diagnosis?
- 24) Do you ever rely on your own dreams to diagnose an illness?
- 25) What day-to-day actions can prevent illness?
- 26) What does the term health mean to you?
- 27) How can someone become healthy?
- 28) What are the different causes of mental illness?
- 29) Can someone cause another person to have a sick mind? How can this happen?
- 30) Can Spirits cause sickness? If so, what kinds?
- 31) Can God cause sickness? If so, what kinds?
- 32) Do people ever become mentally ill because they did something wrong to others?
- 33) Can people become mentally ill for not following certain rules? If so, what might these be?

- 34) Can someone become sick because of something a family member did or didn't do?
- 35) Can someone with a strong spirit make a sick person healthy by being close to them?
- 36) How do you know what is right or wrong? Where does this information come from?
- 37) Can mental/spiritual/physical illness occur by doing something wrong? How? Why?
- 38) Can certain kinds of thinking make people sick? Why? How?
- 39) What causes people to be sad? Happy?
- 40) Can someone become ill by being in the wrong place?
- 41) Can illness be caused by sin? Can any sin cause any illness?
- 42) Have you seen any cases of witchcraft? What causes this?
- 43) Are there any illness that are caused by ordinary natural things?
- 44) Can accidents happen? Or do all things have a purpose and meaning?
- 45) Why do bad things occur to people? Do you know any examples of this?
- 46) Why do good things occur to people? Examples?

Treatment / Healing: (The goal here was to develop an understanding of how healing occurs with specific attention to spiritual aspects of healing and how spirituality can act as either risk or protective factors for mental distress and disorder. In addition, this section also attempts to understand the relations between different aspects of the healing treatment, as between herbal remedies, prayer and biomedicine).

- 1) Are there certain times of the day, year, month or week that are better for treatment? Why or why not?
- 2) How important is the calendar in treating a particular condition?
- 3) What is the role of prayer in healing?
- 4) What is the role of spirits in healing?
- 5) What is the role of God in healing?
- 6) How do you know what treatment is required?
- 7) How do you know if a ceremony is required?
- 8) What does a ceremony do? How does this help treat the illness?
- 9) Do you treat the person or the illness condition? Or is there even a distinction?
- 10) Can you treat someone's mind without treating the body?
- 11) How do you treat someone with an illness of the spirit?
- 12) How do you know when sacrifice is required for a treatment?
- 13) How does sacrifice help the patient?
- 14) What is the role of the four directions in treatment? Is this always important?
- 15) What is the role of candles during treatment?
- 16) Can you treat someone from a distance? Have you ever done this?
- 17) What is causing the person to become healthy?
- 18) Are there times where you cannot treat a person? Why not?
- 19) Are there spiritual forces that help with the treatment? What are these called? How do you use them? How do you know they are present?
- 20) What is the role of the patient during a healing treatment?
- 21) Does the patient have to understand the prayers you are saying for them to work? Why? Or why not?
- 22) In what language are you praying?
- 23) Where do you pray? For how long? What are the actual words you are saying in the prayer?
- 24) Is it important to have the words exactly "right" during the prayer?

- 25) How long do treatments take?
- 26) Do you have to touch the patient during treatment? Why or why not? Are some conditions different in this regard?
- 27) Can you heal through prayer alone?
- 28) Can God heal the patient without your help?
- 29) Where does healing have to occur? Are there certain cases where you have to be in a certain place? Are some places better than others for treatment? Why? What is it about a place that can help with healing?
- 30) Does a patient have to know what you are doing in order to feel healthy?
- 31) Do you have to tell the patient what kind of illness they have? Is this important?
- 32) Can you charge objects with spiritual power? How does this work? Can anyone learn to do this? Why or how does this happen?
- 33) What is the role of herbs during treatment? How do prayer and herbs work together?
- 34) Do you ever tell a plant what you need it to do?
- 35) If you do not say a prayer first, will the plant still work?
- 36) What is the role of family during treatment?
- 37) Who needs to be present during a healing treatment?
- 38) Is it God's will for someone to be healed?
- 39) Are there times when God or spirits wish a person to remain ill? Why or why not?
- 40) Do you ever do multiple treatments with a person?
- 41) Are there things you need to do before healing? Does your spirit/mind/body need to be strong? How does this happen?
- 42) Why do you need permission to use herbs? Who are you asking permission from? What happens if you don't ask permission? Will the treatment still work?
- 43) Can certain kinds of thinking make us healthy?
- 44) How can mountain spirits make us sick? Healthy?
- 45) Why is it important to burn incense during treatment? Who is this for?
- 46) Why do you have to exchange things during a ceremony?
- 47) How can an object take on part of the sickness?
- 48) Do all conditions require herbal remedies?
- 49) Why do you have to be careful where to place an object used in a ceremony after its use? Why be careful of how you dispose of plants after use?
- 50) Is health contagious?
- 51) Can healers ever "share" the illness experience?
- 52) When you heal, do you feel the sickness being healer?
- 53) What is your connection to the patient? How important is a relationship between the healer and the patient for healing to work?

Conceptualization of Efficacy: (The purpose here was to understand how a healer knows when a treatment works, what constitutes a "cure" and what factors lead to these understandings. Also, it will be most fruitful to address many of these questions in the context of specific healing cases).

- 1) How do you know if a treatment has worked?
- 2) What are the factors that contribute to a successful healing treatment?
- 3) When might a treatment not be successful?
- 4) What does it mean to successfully heal someone?
- 5) How do you know if someone is feeling better?

- 6) Do you ever go back after a treatment to see how a patient is doing?
- 7) Does someone become healthy all at once or more in stages? What are these stages?

Medical systems and Biomedicine: (The purpose here was to understand how Q'eqchi' healing interacts with or integrates ideas, techniques and perspectives from biomedicine and whether medical practice is seamless across different systems or contested between these two areas).

- 1) What is medicine?
- 2) What are the different kinds of medicine?
- 3) Do all medicines do the same things?
- 4) Are some medicines better than others?
- 5) What makes something a good medicine?
- 6) Do you ever send patients to another healer? Why or why not?
- 7) Have you ever sent a patient to a hospital?
- 8) Do you ever go to the hospital?
- 9) Have you ever worked with a doctor from a hospital?
- 10) Would you like to work with a doctor from a hospital?
- 11) What is the difference between your knowledge and the knowledge of a doctor from a hospital?
- 12) Are there things you can do that the hospital cannot? What are these? Why can't the hospital do them too?
- 13) Do you think healers like yourself should work in hospitals?
- 14) How would you describe the medicine used in hospitals?
- 15) Do you ever use the medicine that is used in hospitals?

b) Patient interviews:

Illness Experiences: (The goals here was to develop an understanding of the treatment hierarchy of resort for particular Q'eqchi' individuals with specific illness conditions. In addition, these questions were used to generate case studies of specific treatment encounters and illness experiences. Many questions for the patients will be similar to the healers except for an added focus on the actual experience of being ill).

- 1) What is it like for you to be ill?
- 2) Can you describe how you feel?
- 3) How did you become ill?
- 4) What is the condition you are suffering from?
- 5) Do you think there is a reason why you become sick? What do you think that is?
- 6) Did spirits make you sick?
- 7) Can illness be prevented? When are some times where illness cannot be prevented? When are some times when it can?
- 8) How does your family feel about your condition?
- 9) What is different now then before you became ill?
- 10) How does your body feel?
- 11) Do you pray when your sick? Does this help you feel better? Are there times when prayer can make you feel worse?
- 12) Did you understand the specific words used in the healers prayer?
- 13) What is difficult for you now that you are sick?

- 14) What are some things that make you feel better?
- 15) Have you gone to see a healer? Why or why not?
- 16) Have you gone to a hospital? Why or why not?
- 17) What was the first thing you did when you found out you were ill?
- 18) How did you know that you became ill?
- 19) How do you know when you will become healthy?
- 20) Do you think you can become healthy again?
- 21) Did God make you sick?
- 22) Is there anything you can learn from your sickness?
- 23) When did you first seek help for your condition? What did you do? Did that work? Why or why not? Did you change about how you thought of the illness after? What did you do next?
- 24) Why did you decide you needed help with your condition?
- 25) Can you treat the condition your self? Why or why not?
- 26) How do you feel after the treatment?
- 27) What did the treatment do for you?
- 28) What has your family done to help with your condition?
- 29) Are there spirits that can help with your condition? Why or why not?
- 30) Is your illness condition only in your body, or is it in your mind and spirit as well?
- 31) What are some things that protect people from getting sick?
- 32) Can someone else become sick for something you did?
- 33) Do people get sick at certain times of the year?
- 34) Do you still work now that you are sick?
- 35) Do you think other people can become ill because you are ill?
- 36) Have you or did you feel some kind of presence during healing?
- 37) Do you feel a close relationship to the healer that treated you?

Appendix E: Oral consent protocol guides

Oral Consent Protocol [to be translated on site into Q'eqchi']

My name is Andrew Hatala and I work in a school in Canada. I also work with the healers who work in this centre. They have asked me to do this work.

The purpose of this work is to develop a better understanding of how their healing works here in the centre. We will use this information to explain to others about Q'eqchi' healing and to help the healers make their centre better.

You (or your child) have/has just been treated by the healer. I would like to ask you a few questions about your (his/her) problem and the treatment you (he/she) have received. This will only take a few minutes.

I would also like to talk to the healer about your (his/her) treatment, if you agree. My school has approved this project and the questions I will ask. The healers who work in this centre have also approved these questions. But they will not see your answers. If you agree, you, Mr Victor [the centre coordinator] and I will go into this room to talk. I will want to record our conversation so that I may have it written out later. This will help me do this work.

What you tell me will be heard only by me, the coordinator and a language translator. Once I write up our conversation, no one else will see what you have told us unless they are a part of this project. We will not tell anyone what you tell us. We will not tell the healer what you told us. We will not use your name. We will lock up all your information so no one can see it. You do not have to agree to talk to us. If you do not want to talk to us, you will still be welcome to be treated by the healers at this centre.

If you change your mind after we interview you, you can tell us and we will erase the recording of our conversation.

If you have more questions about this project you may ask the coordinator at any time during centre hours. You are also welcome to drop in any time to learn more about the project and what we are learning.

For signed adult consent or consent for child:

I understand what has been said to me and I would like to do this.

Participant's Name:

Participant's/Parent's Signature or Mark:

Researcher:

Date:

For assent by child:

Participant's Name/Parent's Name:

Participant's/Parent's Signature or Mark:

Researcher:

Date:

For oral consent without signature:

I had the contents of this consent form translated into Q'eqchi' and orally delivered to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

Participant's Name/Name of Parent Consenting (if appropriate)

Researcher:

Date:
